

INTRODUCTION TO PRINCIPLES OF MEDICARE REIMBURSEMENT



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INTRODUCTION TO PRINCIPLES
OF
MEDICARE REIMBURSEMENT

HEALTH CARE FINANCING ADMINISTRATION
MEDICAID/MEDICARE MANAGEMENT INSTITUTE

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PREFACE

The Introduction to Principles of Medicare Reimbursement is NOT a substitute for the Provider Reimbursement Manual, HIM-15. Although both contain the same basic information about the principles of reimbursement to providers, the Provider Reimbursement Manual is the official manual.

The Introduction to Principles of Medicare Reimbursement is an informational guide to be used only in conjunction with the Provider Reimbursement Manual, related regulations, and other official publications. You may use this guide to assist with explanations and interpretations of the material in the official publications. The guide also discusses the history and background which influenced the development of the principles of reimbursement to providers.

To be sure that you have the most current and up-to-date policy and instructions for provider reimbursement, you must use the Provider Reimbursement Manual, the related regulations, Intermediary Letters, and other available sources of official information. Deductibles and co-insurance amounts, as well as other information, are subject to change.

ACKNOWLEDGMENTS

Preparing this "simplified" Introduction to the Principles of Medicare Reimbursement has been a long and difficult task. It took much longer to complete than I expected because I learned it was not easy to translate technical accounting language into language which everyone could understand. The task was made easier by the support and encouragement I received from a number of HCFA staff.

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Morris Older
November 1981

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CHAPTER 1

INTRODUCTION AND BACKGROUND

Medicare, Title XVIII

Medicaid, Title XIX

Maternal and Child

Health and Crippled

Childrens Services - Title V

INTRODUCTION

The idea of making health care available to the aged and to the poor and needy did not start in 1965 when Public Law 89-97, Health Insurance for the Aged and Medical Assistance, was passed. As far back as 1935, when the original Social Security Act was passed, there had been Congressional activity in the health care field.

As often happens in a democratic society, it took many years between the birth of the idea of making health care available to the aged and the poor and needy and the passage of Public Law 89-97 in 1965. From 1935 on, bills were introduced periodically in Congress to establish a government health insurance program but none came out of committee. The bills differed widely in the number of persons covered, range of services provided, method of financing, and degree of participation by the States.

One of the most significant of the bills introduced was proposed by Senator Wagner, Senator Murray, and Congressman Dingell. They proposed the most comprehensive social insurance measure introduced in Congress up to that time. It included a nationally sponsored health insurance program, permanent and temporary disability benefits, and maternity and death benefits. The Wagner-Dingell bill had strong support from President Truman but failed to pass after several years of bitter debate on the subject of health insurance. The American Medical Association strongly opposed Federal health insurance, and many States resented what they considered to be Federal interference in local health and welfare matters.

However, support for the social security approach to health insurance was growing among organized groups in the country. The organized groups included labor groups, especially the AFL-CIO, the Group Health Association, the American Public Welfare Association, the American Nurses Association and the National Association of Social Workers. Senior citizens over 65 began to organize and pushed for passage of a Federal health insurance program.

Nevertheless, Congress was still subjected to pressure from groups opposed to governmental health insurance and it began to look for a compromise. The compromise, reached late in August 1960, was called the Kerr-Mills Act, named for its authors in the Senate and House of Representatives. Essentially, it was a public assistance program.

Under the Kerr-Mills Act, Federal financial assistance was available to any State that elected to participate in a program of medical assistance to the aged. Federal funds would assist in the payment for a wide range of services, hospitalization, physicians' and surgeons' care, private duty and visiting nurse service, nursing home care, and outpatient services. The decision regarding the services to be provided was left to the individual State.

Another provision in the Kerr-Mills Act extended the public assistance program by making it possible for a State to give financial assistance to the aged who were not receiving old age assistance, i.e., people who were not indigent but who could not meet the catastrophic costs of a major medical expense. They were called the "medically indigent." Like the indigent, they would have to be subjected to a means test to determine eligibility for assistance.

The Kerr-Mills Act was not accepted by the States with any great enthusiasm. Eighteen months after enactment, only slightly more than half the States had adopted the program.

Congress held hearings on new legislative proposals during the next four years but no positive action was taken. However, support for health insurance programs continued to grow and in 1965 Congress finally adopted a program that provided health insurance for the aged and the medically needy, when it passed Public Law 89-97.

Public Law 89-97, Health Insurance for the Aged and Medical Assistance, was signed into law on July 30, 1965. It became effective on July 1, 1966 (except for skilled nursing facilities which became effective on January 1, 1967). The law added two new titles to the Social Security Act, Title XVIII, Health Insurance for the Aged, and Title XIX, Grants to States for Medical Assistance Programs.

The legislation called for an extraordinary package of health benefits and social security improvements. Title XVIII, Medicare, established a health insurance program for persons aged 65 and over. Part A of Medicare helps pay for care in hospitals, skilled nursing facilities (nursing homes) and related health institutions. Part A is financed through contributions from employers and employees through the social security system. Part B of Medicare helps pay for physicians' care and other health services. Part B is financed through monthly insurance premiums paid voluntarily by enrollees in the Medicare program. The enrollee's voluntary premium is matched by a Federal contribution.

Medicare is a Federal program and is the same all over the United States.

Title XIX, Medicaid is an assistance program. It pays medical bills for needy and low income people who are aged, blind, disabled, or members of families with dependent children. Medicaid is a Federal-State partnership and varies from State to State. Each State designs its own Medicaid program within Federal guidelines. Medicaid is financed jointly with State and Federal funds; the Federal contribution to the cost of the program ranges from 50 percent to 83 percent.

It is important to remember that the main purpose of Public Law 89-97 was to help older people meet the cost of the medical care they receive. The program itself does not provide care nor does it make changes in the way medical care is given.

MEDICARE (Title XVIII)

The following section describes some of the highlights of the Medicare program (as of July 1, 1980) from the point of view of the beneficiary. It describes the covered services to which the beneficiary is entitled and the costs or fees the beneficiary must pay. For more detailed information, see "Introduction to Medicare" (HCFA Publication No. 10005) or "Your Medicare Handbook" (HEW Publication No. SSA 05-10050).

Medicare is a Federal health insurance program for people aged 65 and older and, beginning in July 1973, for disabled persons and for persons with chronic renal disease, regardless of age.

The Medicare program has two parts:

1. Hospital Insurance (Part A)

Hospital insurance helps pay for services received when a beneficiary is an inpatient in a hospital or in a skilled nursing facility, or when the patient is at home and receives services from a Home Health Agency.

This coverage is available to nearly everyone age 65 or older who has had Social Security coverage and to disabled persons and persons with chronic renal disease.

2. Medical Insurance (Part B)

Medical insurance helps pay for doctors' services, outpatient hospital services, outpatient physical therapy or speech therapy, home health services and many other health services not covered by hospital insurance.

Part B coverage is voluntary. In most cases the beneficiary is automatically enrolled but has the option to decline the coverage. Beneficiaries pay a monthly premium (\$11.00 as of July 1, 1981) for medical insurance protection.

HOSPITAL INSURANCE (PART A)

The hospital insurance program is financed by contributions from employees, with employers paying an equal amount. Self-employed persons also contribute. These contributions are collected along with regular social security contributions from wages and self-employment income earned during a person's working years.

These contributions are put into the Hospital Insurance Trust Fund from which the program's benefits and administrative expenses are paid.

The beneficiary is also responsible for a deductible amount (\$204 in 1981) payable when he enters a hospital for services. (NOTE: The hospital deductible is based on an average cost per inpatient day as determined by the Secretary, HHS.)

For the first 60 days in a hospital, hospital insurance (Medicare, Part A) pays for all covered services except for the deductible of \$204 which is paid by the beneficiary.

For the 61st through the 90th day, hospital insurance pays for all covered services but the beneficiary pays a daily amount for coinsurance, \$51 per day in 1981.

Once the beneficiary has paid the deductible (\$204) in each "benefit period," he or she does not have to pay it again even if he or she has to go back in the hospital more than once in the same benefit period.

A "benefit period" begins the first day beneficiary enters a qualified hospital or skilled nursing facility. The benefit period ends as soon as the beneficiary has not been an inpatient of any hospital or other facility primarily providing skilled nursing or rehabilitative services for 60 successive days.

After such a 60-day period, a beneficiary can start a new benefit period and renew his or her entitlement to full hospital insurance benefits the next time he or she enters a qualified hospital or skilled nursing facility. There is no limit to the number of benefit periods a beneficiary may have.

Hospital insurance will help pay for the following covered services:

- Semi-private rooms (2, 3, or 4 beds)
- Private room if medically necessary
- All meals, including special diets
- Operating room charges
- Nursing services
- Drugs furnished by the hospital
- Laboratory tests
- X-ray and other radiology services
- Necessary medical supplies
- Medical social services

The following are noncovered inpatient hospital services:

- Private duty nurses
- Personal comfort or convenience items furnished at patient's request
- Any extra charge for a private room
- Doctors' services
- Services not reasonable and necessary for the treatment of an illness or injury

Hospital insurance pays for all covered services in a participating skilled nursing facility (SNF) for the first 20 days the beneficiary received such services in each benefit period. Hospital insurance pays all but \$25.50 per day for the next 80 days in the same benefit period. The beneficiary pays the \$25.50 per day after the 20th day. Hospital insurance does not pay for any SNF covered services after 100 days in the same benefit period.

Hospital insurance also pays for continuing care provided by a home health agency (HHA) when the patient is confined to his home. The continuing care must include part-time skilled nursing services or physical or speech therapy. Hospital insurance will pay for as many as 100 home health visits in a benefit period. There is no deductible or coinsurance to be paid by the beneficiary.

One visit is counted each time a beneficiary receives a covered health service from a HHA. If he receives two different services on the same day, e.g., from a nurse and from a physical therapist, it counts as two visits.

The following services are noncovered home health services:

- Full-time nursing care
- Drugs and biologicals that can be self-administered
- Personal comfort or convenience items
- Meals delivered to the home
- Services not reasonable and necessary for the treatment of an illness or injury

MEDICAL INSURANCE (PART B)

The Part B program is financed in part by premium payments of individuals enrolled in the program, premium payments by the States on behalf of public assistance recipients, and the balance by the Federal government out of general revenue. The funds received are deposited in the Supplementary Medical Insurance Trust Fund and Part B costs are paid out of the same trust fund.

In addition to paying the monthly premium (\$11.00 beginning July 1, 1981), the beneficiary is responsible for paying the first \$60 of reasonable charges for covered services in each calendar year. Part B medical insurance pays 80 percent of the reasonable charges in excess of the first \$60 during the same calendar year and the beneficiary pays - or is responsible for - the remaining 20 percent of the reasonable charges.

NOTE: There is only one \$60 medical insurance deductible in each calendar year, not a separate deductible of \$60 for each kind of covered service.

Medical insurance will help pay for doctor bills for all covered services. The doctor may treat a beneficiary in his office, a hospital, a skilled nursing facility, the beneficiary's home or at a clinic or a group practice or health maintenance organization.

Covered services under medical insurance (Part B) include:

Medical and surgical services by a doctor of medicine or osteopathy

Services by a dentist but only if it involves surgery of the jaw or contiguous structures or setting of fractures of the jaw or facial bones.

Diagnostic tests and procedures

Medical supplies

Services of the office nurse

Drugs and biologicals which cannot be self-administered. Services rendered by a physical therapist or speech therapist. Ambulance services to a hospital or to a skilled nursing facility or to the patient's home.

Outpatient hospital services such as laboratory, X-ray and other radiology services, emergency room or outpatient clinic services, medical supplies such as splints and casts, and other diagnostic services.

Noncovered services under medical insurance (Part B) includes:

Routine physical checkups

Routine foot care and supportive devices for the feet

Eye refractions and examinations for prescribing, fitting, or changing eyeglasses

Cosmetic surgery unless it is needed because of accidental injury or to improve the functions of a malformed part of the body.

Routine dental care

Hearing examinations for prescribing, fitting, or changing hearing aids

Immunizations not related to injury or immediate risk or infection

MEDICAID (Title XIX)

The following section describes some of the highlights of the Medicaid program (as of July 1, 1980).

It may be helpful to begin by comparing Medicare (Title XVIII) and Medicaid (Title XIX) to point out the similarities and the differences in each program.

Both Medicare and Medicaid were included in Public Law 89-97 which was passed in 1965. Both Medicare and Medicaid are administered by the Health Care Financing Administration (HCFA) in the Department of Health and Human Services (HHS).

Both programs help pay medical bills but they are not the same. Medicare is an insurance program and pays medical bills for insured people. Medicaid is an assistance program and pays medical bills for needy and low income people who are aged, blind, disabled, or members of families with dependent children.

Medicare is a Federal program and is the same all over the United States. Medicaid is a Federal-State partnership and varies from State to State. Each State designs its own Medicaid program within Federal guidelines. Medicaid is financed jointly with State and Federal funds, with the Federal contribution to the cost of the program ranging from 50 percent to 83 percent.

Medicaid is designed to provide medical assistance to those groups of people who are eligible to receive cash payments under one of the welfare programs established under the Social Security Act. These are the Aid to Families With Dependent Children (AFDC) program and the Supplementary Security Income (SSI) program for the aged, blind and disabled.

In addition, States may provide Medicaid to the "medically needy," that is, to people who fit into one of the categories of people covered by the cash welfare programs, aged, blind, or disabled individuals, or members of families with dependent children when one parent is absent, incapacitated or unemployed. These "medically needy" people may have enough income to pay for their basic living expenses but not enough to pay for their medical care.

It is important to remember that not all needy people automatically qualify for Medicaid. Recipients must not only pass a means test, but they must belong to one of the groups designated for welfare eligibility, i.e., aged, blind, disabled or members of families with dependent children.

Federal law under Title XIX requires that certain basic services must be offered in any State Medicaid program. These are:

Inpatient hospital services, other than those in an institution for tuberculosis or mental disease

Outpatient hospital services

Laboratory and X-ray services

Skilled nursing facility and home health services for those 21 and over

Physician's services

Family planning

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for those under 21

Rural health clinic services as consistent with State law

In addition, States may provide a number of other services if they elect to do so. They may include:

Private duty nursing services

Clinic services

Dental services

Physical therapy, occupational therapy and treatment of speech, hearing, and language disorders

Prescribed drugs, dentures, prosthetic devices, and eyeglasses

Other diagnostic, screening, and rehabilitative services

Inpatient hospital services, SNF services, and intermediate care facility (ICF) services for persons 65 or over in institutions for tuberculosis or mental disease

ICF services, including ICF services for the mentally retarded in institutions other than tuberculosis hospitals or mental institutions, for persons determined to be in need of such care as specified in the Social Security Act

Inpatient psychiatric services for those under 21

Any other type of medical or remedial care recognized under State law and specified by the Secretary of HHS

The basic services which are mandatory under Title XIX must be provided without charge to the needy recipient. The State may impose nominal deductibles or co-payment on optional services for the categorically needy, and on all services, mandatory and optional for the medically needy.

The Medicaid agency must have arrangements to assure that recipients can get to and from providers of care. They must also allow recipients free choice among qualified providers.

Many persons are covered under both the Medicare and Medicaid programs. As described earlier, coverage of inpatient hospital services (Part A of Medicare) is almost automatic for persons aged 65 and over and for certain disabled persons; coverage for the supplementary medical insurance program (Part B of Medicare) requires payment of a monthly premium.

Many States make this payment of the monthly premium for their Medicaid eligibles who are also eligible for Medicare. These "buy-in" agreements allow Medicare coverage for those Medicaid/Medicare eligibles who might not be able to afford to pay the Part B premium on their own. When persons are eligible under both programs, Medicare makes the principal payment for the service, and the State Medicaid agency pays the deductible and co-payment amounts.

Besides paying premiums, deductibles, and co-payments for persons who are eligible for Medicare, State Medicaid programs also provide many services for the aged and disabled that are not provided by Medicare. For example, the State may provide skilled nursing care beyond the 100-day post hospital benefit provided by Medicare, prescription drugs, eyeglasses, hearing aids, etc. Medicaid expenditures for the aged basically supplement Medicare coverage.

It should be noted that all States require Medicaid patients in long term care institutions to contribute their excess income (generally, all income over the \$25 monthly they require for personal needs), to help pay for the cost of their care. Similarly, all medically needy individuals who have income that exceeds the amount set for Medicaid eligibility must use their excess income to pay for their medical care until they have spent their income down to the Medicaid level.

Each State determines the scope of services offered. For example, States may limit the number of days of hospital care or the number of doctors' visits covered. They also determine the reimbursement rate for services, except for hospital care.

States are required by law to reimburse for inpatient hospital services on the basis of reasonable cost following the reimbursement practices of Medicare, unless they have approval from the Secretary, HHS to use an alternate method of reimbursement. The Secretary will approve an alternate system which varies from the Medicare method only if satisfied that:

1. reasonable cost is paid, and
2. the reasonable cost does not exceed the amount which would be determined as reasonable by Medicare.

For all other services, including physician services, outpatient hospital services, and skilled nursing facility services, States are not required to use the Medicare method of payment. In fact, the only requirement is that the State Medicaid reimbursement may not exceed the amounts paid under Medicare.

There is an exception, however, for skilled nursing facility services and intermediate care facility services. In the case of skilled nursing facility services and intermediate care facility services usually in long term care institutions, a State is subject to the additional requirement that its payment system must be reasonably related to cost. This means that States are not required to use the Medicare reasonable cost system (although they may use it if they wish), but they must relate their reimbursement to the cost of care in some reasonable way, whether determined prospectively or retrospectively. Use of a cost-related payment system for long term care institutional services has been required by law since July 1, 1976.

Medicaid operates as a vendor payment program. Payments are made directly to the provider of service for care rendered to an eligible individual. Providers must accept the Medicaid reimbursement level as payment in full.

Thirty-eight States employ 57 fiscal agents to handle one or more aspects of claims payments. Fiscal agents include Blue Cross and Blue Shield Plans and commercial insurance companies. About 15 States, or other jurisdictions, handle all claims payments themselves. States prepare their own definitions of what is reimbursable within generally broad Federal definitions.

In some States, fiscal agents act solely as bill payers. In other States, fiscal agents may perform various functions ranging from design of forms to writing manuals; usually the functions are defined in the arrangements between the State and the fiscal agent.

MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES (Title V)

The purpose of Title V, Maternal and Child Health and Crippled Children's Services is:

1. to enable each State to extend and improve services for reducing infant mortality;
2. to improve the health of mothers and children; and
3. to promote surgical, medical, corrective and other services for diagnosis, hospitalization, and aftercare for children who are crippled or suffering from conditions leading to crippling.

In order to be entitled to payments under Title V, a State must have a plan for maternal and child health services and services for crippled children which provides for:

1. financial participation by the State;
2. administration of the plan by a State health agency;
3. payment of reasonable cost of inpatient hospital services provided under the plan but not to exceed the amount determined to be reasonable under Title XVIII, Medicare;
4. early identification of children in need of health care through periodic screening and diagnostic services;

5. promoting the health of children of school or preschool age, including dental health services, and optometrist services; and by reducing the incidence of mental retardation caused by complications associated with child bearing.

Title V and Title XIX, the Medicaid program, are both State-administered programs and both programs use many of the same hospitals for inpatient and outpatient services. It is customary for the State officials of each program to try to cooperate with each other and with Title XVIII, Medicare, to establish consistent methods and principles for the payment of reasonable cost.

A State has the option of adopting the reimbursement methods and principles of Medicare, Title XVIII, or developing alternative methods and principles. If an alternative option is selected, it is required to satisfy Federal requirements as well as the State requirements, and the option must be approved by the Regional Health Administrator prior to its implementation. The amount of reimbursement may not exceed the amount which would be payable under Title XVIII.

CHAPTER 2

PRINCIPLES OF REIMBURSEMENT - GENERAL

PRINCIPLES OF REIMBURSEMENT - GENERAL

The principles of reimbursement for provider costs were developed primarily by, and for, the Medicare program, Title XVIII.

Under the Medicaid program, Title XIX, the law requires States to reimburse for inpatient hospital services on the basis of reasonable costs. States are directed to follow the reimbursement principles of Medicare for inpatient hospital services unless they have approval from the Secretary of HHS to use an alternate method of reimbursement. States are not required to use Medicare reimbursement principles for any of the other services, including outpatient hospital services, skilled nursing facility services, and physicians' services.

Where a State does not use a fiscal intermediary to determine reasonable costs (using instead a State agency, e.g., the State health department), if the State has any question about its reasonable cost, it may contact the Medicare intermediary in its area for information and data.

The Maternal and Child Health and Crippled Children's Service is required to pay the reasonable cost of inpatient hospital services but not to exceed the amount determined to be reasonable under Medicare.

Thus, the principles of reimbursement for provider costs are used by Medicare for hospital costs, for skilled nursing facility costs, and for home health agency costs.

The reimbursement principles are used to a lesser degree by Medicaid for inpatient hospital services only, the reasonable cost principles are used by the Maternal and Child Health and Crippled Children's Service program.

Because there are wide variations in size and scope of services rendered by providers, some of which arise out of regional differences, the reimbursement principles are flexible on many points. The principles offer some alternatives and options designed to fit individual provider circumstances. However, before any payments can be made to a new provider, the intermediary must review the fiscal and other records to assure that the provider has an ongoing system for furnishing the records needed to provide accurate cost data and other information for cost reporting purposes. The cost data must be capable of verification by qualified auditors.

One of the major principles required by law is that the amount paid to any provider for the covered services furnished to beneficiaries (Medicare patients) must be the reasonable cost of such services. Reasonable cost is determined by providers and their fiscal intermediaries by using these reimbursement principles and related guidelines and procedures.

FISCAL INTERMEDIARIES

Fiscal intermediaries are generally Blue Cross Plans and commercial insurance companies which have contracted to handle the payment of claims on behalf of the Medicare program, using the principles of reimbursement and related guidelines. Fiscal intermediaries are nominated by hospitals, skilled nursing facilities, or home health agencies but must be approved to serve as fiscal intermediaries by the Secretary of HHS.

A provider may elect to deal directly with the Health Care Financing Administration (HCFA) but the same principles of reimbursement are used in making payment for services.

The fiscal intermediaries are responsible for paying participating hospitals and other providers for the covered services received by Medicare patients. In addition to claims processing and payment, intermediaries furnish consultation services to providers in the development of accounting and cost finding procedures to ensure the provider will receive equitable payment under the program.

In essence, the intermediary is the primary contact between the provider and the Medicare program. The intermediary makes interim and final payments for cost of services rendered by the provider to Medicare patients and answers any questions the provider may have about the program. In the normal course of events, the intermediary is the provider's only contact with the Medicare program.

Another requirement of the law which established the Medicare program was that payment formulas should be developed which assure that no part of the program's share of the total cost incurred by the provider is borne by other patients. Conversely, costs attributable to other patients of the provider are not to be borne by the program.

In general terms, the objectives of the reimbursement principles are:

1. That the methods of reimbursement should result in current payment so that providers will not have to pay out money for the purchase of goods and services long before they receive reimbursement.
2. That, in addition to current payment, there should be retroactive adjustments so that any increases in costs are taken fully into account as they actually occur, not just prospectively.
3. That there be a division of the total allowable costs between the provider's Medicare patients and its other patients that takes account of the actual use of services by Medicare patients, and that the division of total costs is fair to each provider.
4. That the reimbursement principles should result in the equitable treatment of both nonprofit organizations and profitmaking organizations.
5. That there should be a recognition of the need of hospitals and other providers to keep pace with growing needs and to make improvements.

Before we get into the specifics of reimbursement principles, guidelines, and methods, let's take an overall look at how the Medicare program works.

A Medicare patient entering a hospital presents his or her Health Insurance card. The hospital checks with the intermediary as to the patient's eligibility, previous admissions, and whether any benefits have already been received by the patient during this particular spell of illness (benefit period). The patient is treated by his or her physician, surgeon, and hospital staff, and is discharged by the hospital when his or her condition has improved, stabilized, or when he or she has died.

The Medicare program does not pay the hospital separately for each patient; this would be an almost impossible task. Instead, the Medicare program pays the hospital on the basis of an annual cost report filed by the hospital.

However, since it would obviously be unfair to make a provider wait for reimbursement until it has filed its cost report, the intermediary makes interim payments to the provider monthly or more frequently. The amount of the interim payments is based on an estimate of the actual costs incurred but not to exceed customary charges for the services rendered, or limits on costs in excess of those necessary in the efficient delivery of needed health services.

As mentioned above, the hospital prepares a cost report at the end of its Medicare cost reporting period. The preparation of the cost report is quite technical and involved since it is designed to determine the actual cost of services rendered to Medicare patients. Providers' costs consist mainly of employee salaries and wages, supplies, and depreciation. Medicare reimbursement takes all costs into account, but subject to the limits mentioned above.

Medicare pays its share of the total reasonable costs which were necessary and related to patient care. Medicare's share is based on the ratio (percentage) of the cost of services rendered to Medicare patients to the total cost of such services.

For example, assume that the total charges in the radiology department in a hospital amounted to \$100,000, of which \$40,000 was charged to Medicare patients. The ratio of Medicare charges to total charges is \$40,000 to \$100,000 or 40 percent of the total. It can be assumed that Medicare patients used 40 percent of the services, therefore, Medicare owes the hospital 40 percent of the costs incurred in the radiology department.

(Note that it is quite possible that the number of Medicare patients in the hospital represented only 30 percent of the hospital's total number of inpatients (say, 30 out of 100), but the Medicare patients received 40 percent of the services rendered in the radiology department, therefore, Medicare owes 40 percent of the cost in that department.)

The cost report is filed with the hospital's intermediary who reviews it, compares it against other similar hospitals in the area, and performs an audit where deemed necessary or advisable.

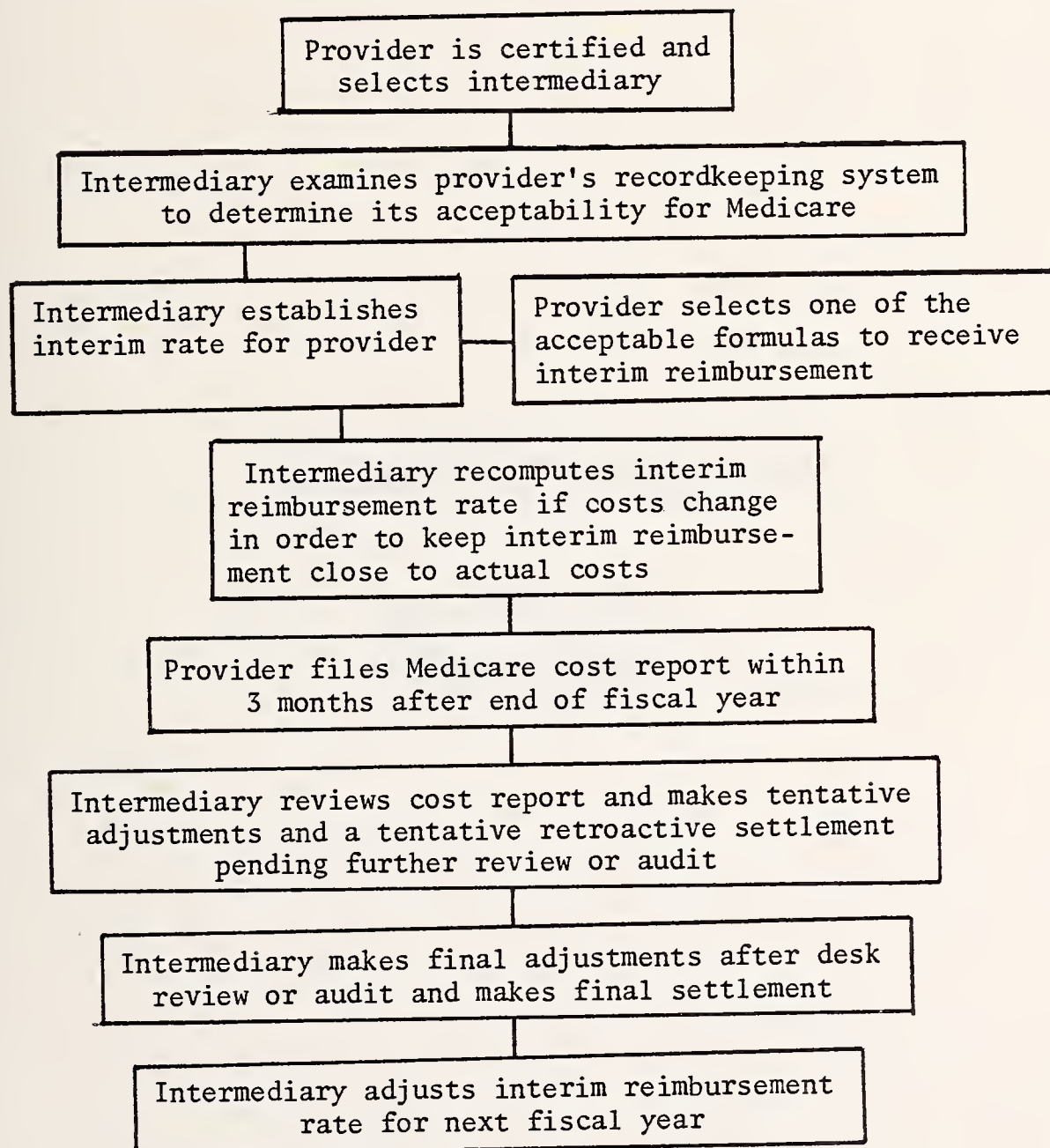
After the cost report has been reviewed by the intermediary, the intermediary discusses the adjustments it made to the cost report with the provider. Although it is preferable that the provider agree with the intermediary's

adjustments, it is not a requirement for final settlement. The intermediary usually makes every effort to reconcile and adjust any differences with the provider.

The intermediary then prepares a settlement made up of the difference between the total actual costs incurred and the total interim payments made during the period plus or minus any other monies owed to the program by the provider. Any overpayment must be repaid to the Medicare program and any underpayment is paid to the provider.

The following chart describes the steps in payments to providers.

MEDICARE PAYMENTS TO PROVIDERS OF SERVICES



CHAPTER 3

COST APPORTIONMENT AND COST FINDING

Departmental Method

Combination Method (Not
allowable after July 1, 1979)

COST APPORTIONMENT AND COST FINDING

INTRODUCTION

In brief, the principles of reimbursement recognize such costs as salaries and wages paid to employees, depreciation, interest, bad debts, educational costs, compensation of owners, an allowance for a reasonable return on equity capital for proprietary providers, and a number of other costs. Payments to providers after December 31, 1973, are limited to the lower of reasonable cost or the customary charges made by the provider to the general public for the same services.

We will describe and discuss allowable costs and nonallowable costs in more detail later. However, before we discuss specific costs, you need to learn about "apportionment" and "cost finding," two technical terms which describe the methods used to determine Medicare's share of the total cost of services, as measured by the services used by Medicare patients.

You also need to know there are two general categories of services in hospitals and skilled nursing facilities (SNFs), routine services, and ancillary services.

Routine services, sometimes referred to as the "room and board" charge are those services included by the provider in a daily service charge. Included in routine services are the patient's room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

Ancillary services include laboratory, radiology, drugs, delivery room, operating room, recovery room, and therapy services. Ancillary services also include special items and services for which charges are customarily made in addition to a routine service charge.

APPORTIONMENT

One of the primary requirements in the original law was that reimbursement should be such that "the costs of covered services provided to individuals covered by the health insurance program will not be borne by individuals not so covered, and that costs with respect to individuals not covered will not be borne by the program."

This requirement created the problem of how to apportion costs properly between Medicare patients and the other patients. Reimbursement policies had to take into account the relative use of services by the Medicare patients and the other patients. A review of hospital data and reimbursement practices indicated there were two practical bases available for apportioning allowable costs between Medicare patients and other patients. These were:

1. The relative number of days used by Medicare patients and by other patients.

The average cost per day was computed by dividing the total allowable cost by the total inpatient days. The answer was what hospital accountants call the "average per diem cost."

Medicare's share of the cost could be computed by multiplying the number of Medicare inpatient days by the average per diem cost.

This method is known as the average per diem cost method.

Example

Total inpatient days, all patients	35,000	
Total Medicare inpatient days	10,000	
Total allowable costs	\$4,200,000	
Average per diem cost		\$120 per day
$\$4,200,000 \div 35,000$		
Cost of Medicare services	\$1,200,000	
$10,000 \times \$120$		

2. The relative amount of charges incurred by Medicare patients and the relative amount of charges incurred by all patients.

As long as the same uniform schedule of charges was used for all patients, this method could be used to find the ratio (percent) of charges to Medicare patients to total charges to all patients. The ratio (percent) could then be applied to costs to determine Medicare's share of the total allowable costs.

For example, if the total charges for a hospital department were \$100,000, of which \$40,000 was charged to aged patients and \$60,000 was charged to other patients, it can be assumed that the aged patients used 40 percent of the services. It follows, therefore, that the aged patients were responsible for 40 percent of the cost of that department.

This method is generally known as the RCCAC method or merely RCC method. Translated, the initials stand for the Ratio of Charges to Charges Applied to Cost.

The RCC method could be used to find the ratio of total Medicare charges to the total charges of a hospital; this was called Gross RCC.

The RCC method could also be used to find the ratio of Medicare charges to total charges in each department of a hospital; this was called Departmental RCC.

There were some disadvantages in each method. Use of the number of days of care resulted in an average per diem cost which did not recognize variations in the amount of service which a day may represent. Use of charges as a quantitative measure was not completely satisfactory because hospital charges for services generally did not have a consistent relationship to costs among departments or items. Hospitals generally charged less than cost for room, board and routine nursing services, and charged more than cost for many ancillary services.

Most hospitals wanted Medicare reimbursement to be based on an average cost per diem. But Medicare believed that charges were more responsive in reflecting differences in the use of services among patients and groups than any other generally available basis.

However, it was recognized that any method used could produce some problems of inequity. For this reason it was agreed early in the program, that hospitals should be given an option between a method relatively easy for all hospitals to implement and a method that would reflect more accurately the cost of services provided to Medicare patients. But after some years of experience, Medicare found that providers were choosing the method which reimbursed them the most money, regardless of the accuracy of the costs. As a result, only two methods of apportioning costs for reimbursing inpatient hospital services and skilled nursing facility services were approved until July 1, 1979. (After July 1, 1979, only the Departmental Method was approved.)

The two methods were:

1. Departmental Method

Hospitals with 100 or more beds and hospital-skilled nursing facility complexes with 100 or more beds were required to use the Departmental Method.

In the Departmental Method, Medicare's share of the cost of each ancillary department is determined by finding the ratio of total charges to Medicare patients to total charges for all patients in that particular department. The ratio is then applied to the total cost in that department.

Example: The total cost in Department A was \$80,000. Total charges to all patients treated in Department A amounted to \$100,000 of which \$30,000 was charged to Medicare patients.

- 1) Ratio of charges $\frac{\$ 30,000}{\$100,000} = 30\%$
to Medicare patients
- 2) Medicare's share of
cost of Department A = 30% of \$80,000 = \$24,000

The same RCCAC method is used to find Medicare's share of ancillary costs for each ancillary department, laboratory, radiology, operating room, etc. The total costs of each ancillary department are added to find the total cost of ancillary services.

The cost of routine services is determined by multiplying the number of Medicare inpatient days by the average cost per day (average per diem cost).

A separate computation is made for each special care unit in the hospital, e.g., coronary care unit, intensive care unit, burn unit, etc., using the applicable average cost per day for each special care unit.

The cost of the total routine services, including the cost of special care units, is added to the total cost of ancillary services to find the total operating cost of the provider.

(Note: The separate average cost per diem for special care units is applicable only in hospitals, not in skilled nursing facilities.)

2. Combination Method

Hospitals with less than 100 beds, all skilled nursing facilities, and any hospital-skilled nursing facility complex with less than 100 beds were required to use the Combination Method.

Under the Combination Method, Medicare's share of the cost of most ancillary services was determined on the ratio of total charges to Medicare patients to total charges to all patients for such services. The ratio was applied to the total cost of ancillary services.

(Note - charges for the delivery room and labor room are excluded from the total ancillary charges and likewise, cost for the delivery room and labor room are excluded from total ancillary costs.)

The cost of routine services for Medicare patients is determined on the basis of a separate average cost per diem for general routine patient care plus a separate average cost per diem for each special care inpatient hospital unit. (The separate average cost per diem for special care units is applicable only in hospitals, not in skilled nursing facilities.)

NOTE: For cost reporting periods beginning on or after July 1, 1979, the Combination Method of apportionment was eliminated as an acceptable method to determine allowable costs. The reason was that although the Combination Method originally offered some simplicity in determining allowable costs, legislative amendments since 1972 no longer permitted this simplicity. Even under the Combination Method, allowable costs had to be identified separately for renal dialysis services and for delivery room and labor room services. Additional information and computations were required as a result of the limitation on routine costs and the limitation to the lower of reasonable cost or customary charges.

A survey made by the Medicare Bureau indicated that almost all providers using the Combination Method had the capability to use the more precise and more accurate Departmental Method.

The elimination of the Combination Method gave some options to affected providers before it became mandatory on or after July 1, 1979, as follows:

For cost reporting periods starting on or after January 1, 1978, but before July 1, 1979, providers were permitted to use either the Departmental Method or the Combination Method of apportionment.

If the Departmental Method was used for any period, the Combination Method could not be used for any subsequent cost reporting period.

For cost reporting periods starting on or after July 1, 1979, these providers must use the Departmental Method.

All new providers entering the program on or after January 1, 1979, must use the Departmental Method starting with their first cost reporting period.

Cost Finding

Note that we have been discussing the apportionment of costs to be used to determine Medicare's proper share of the cost of services used by Medicare patients. However, before the provider arrives at the apportionment process, there are a number of preliminary steps which need to be done.

The provider begins working on the cost report with a trial balance prepared from his books and records. The trial balance includes all of the provider's costs, salaries, depreciation, heat and light, supplies, maintenance, interest, research, etc., regardless of whether they are allowable or nonallowable for Medicare. These costs are then adjusted in the cost report to conform to Medicare principles so that only allowable costs remain.

The allowable costs are distributed to revenue producing departments or cost centers, a process called cost finding. (See below for definitions and explanations of cost centers.)

Cost finding may be defined as the allocation of the costs of the general service departments to each other and to the revenue producing departments. The bases for allocation are statistical data that measure the amount of service rendered by each cost center to the other cost centers.

The purpose of cost finding is to determine the total costs of operating each department (cost center) and, of course, the total cost of operating the hospital (or other provider).

In addition to its use in preparing Medicare cost reports, management can use the cost finding process for a number of other helpful management reports. For example, management can use the cost finding process to assess the adequacy of the hospital's rate structure, to prepare reports for other third party payers, or to compare its costs with the costs of other hospitals.

Before we discuss "cost finding," it may be helpful to describe hospital accounting methods which are somewhat different from traditional commercial accounting. In traditional commercial accounting, all of the costs applicable to a department are usually charged to that department. In hospitals, only the direct controlled costs are charged to a department or "cost center." ("Cost center" is the term used by hospitals for departments.). Indirect costs, such as depreciation and interest, and other noncontrollable costs, are entered in separate accounts (also called cost centers) and are distributed through cost finding to the hospital's revenue producing cost centers at the end of the cost reporting period.

Hospitals usually have two types of cost centers, general service cost centers and revenue producing cost centers. General service cost centers are operated for the benefit of the hospital as a whole. Each general service department may render services to other general service departments as well as to revenue producing departments. Examples of general service departments include housekeeping, dietary, maintenance, and supplies.

A revenue producing cost center is defined as a department or group of services for which the patient is billed as a separate item when he/she receives these services. Examples include radiology, operating room, laboratory, and outpatient clinics.

A cost center is defined as a department or subdivision thereof, into which functions of an institution are divided for purposes of cost assignment and allocations. A cost center may be composed of a group of services or a group of employees or both.

Because only direct controllable costs are charged to specific cost centers, the full costs of each cost center cannot be determined until the indirect costs (which were charged to separate cost centers during the cost reporting period) are allocated to the cost centers which have received the indirect cost services.

As we said previously, cost finding means the allocation of costs of the general service departments (cost centers) to each other and to the revenue producing departments (cost centers). The reason for allocating costs of general service departments to each other is in recognition of the fact that the services of some general service cost centers are used by other general service cost centers as well as by revenue producing cost centers. For example, the laboratory department receives services from the laundry department in the form of clean uniforms, and from the plant operation in the form of heat and power. The laundry department may receive services from the maintenance department in the form of repairs. The total costs of each of these departments should include each department's share of the costs of other departments.

When all costs are allocated and when the hospital has completed its cost finding procedure, the total cost of operating the hospital may be determined by adding up the total costs of all the departments.

The order or sequence of allocation of costs depends on the organizational structure of the hospital and the scope of its services during the cost reporting period. It is quite possible that the bases used in the allocation may differ among hospitals.

The Medicare Bureau has recommended specific sequences in allocation of costs. However, providers may request permission to change the sequence if they can satisfy the intermediary that the proposed sequence is more accurate. Changes in the order of allocation and bases of allocation should be made only when such changes would produce significant improvement in the accuracy of the results of the cost finding procedure.

The bases generally used to distribute costs are:

1. Quantity of service

2. Actual dollar amount of service

Quantity of service bases make use of actual counts or reasonable estimate of the amount of service rendered by a department or cost center, e.g., the number of meals served or the number of pounds or pieces of laundry processed, or the number of hours spent in a nursing unit.

The actual dollar amount of service basis is used where the services rendered by a department involve distribution of supplies or other items for which either the purchase price or the amount charged to patients is known or can be determined. This basis can be used, for example, for distributing medical supplies or drugs.

(Other bases for allocation will be discussed when we review specific costs.)

CHAPTER 4

PAYMENTS TO PROVIDERS

Interim Payments

Cost Reports

Hearings and Appeals

Let me remind you again that the Introduction of Principles of Reimbursement to Providers by Health Care Financing Administration is NOT a substitute for the Provider Reimbursement Manual, HIM-15. Although both books contain the same basic information about the principles of reimbursement to providers, the Provider Reimbursement Manual must be used as the official manual.

The Introduction to Principles of Reimbursement to Providers By Health Care Financing Administration should be used only as a textbook or as an overall guide to the Provider Reimbursement Manual or to the related regulations and other official publications. You can use this textbook for explanations and interpretations of the material in the official publications. You can also use it to learn something about the history and background which influenced the development of the principles of reimbursement to providers.

To be sure that you have the most current and up-to-date policy and instructions for provider reimbursement, you must use the Provider Reimbursement Manual, the related regulations, Intermediary Letters, and other available sources of official information.

Introduction

As we mentioned earlier, the Medicare program does not pay a provider separately for each patient. Instead, the program pays the provider on the basis of an annual cost report filed by the provider, showing the total reasonable costs incurred for patient care. Medicare pays for its share of the total reasonable costs on the basis of the ratio (percent) of the cost of services rendered to Medicare patients to the total cost of such services.

Reasonable cost is defined — somewhat — in Section 2102.1 of the Provider Reimbursement Manual (PRM) as follows:

"Reasonable cost takes into account both direct and indirect costs of providers, including normal standby costs. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by others not so covered, and the costs with respect to individuals not so covered will not be borne by the program."

It's not easy to define the "reasonable" in reasonable costs. It might be defined as the amount a prudent and cost-conscious provider would pay for a specific item or service if the provider were spending its own money with no hope of reimbursement from third-party payers. The provider would certainly try to minimize its costs within the limits of the quality required.

As for "direct" and "indirect" costs and "normal stand-by costs," these are accounting terms which you may understand more clearly through some examples.

In the radiology department of a hospital, direct costs include, for instance, the cost of X-ray films, the salaries and wages of the technicians, and the cost of the powders, solutions and other supplies needed to develop the X-ray films. The indirect costs in the radiology department include depreciation of the X-ray equipment, an appropriate portion of the cost of heat and light, laundry, maintenance, administration, office supplies, telephone, etc.

In the dietary department of a hospital, the direct costs include the cost of raw food, the labor costs of employees who prepare the food and of those who serve the food to patients or to customers in the hospital cafeteria. The indirect costs include depreciation of kitchen equipment, and an appropriate portion of the costs of laundry, heat and light, maintenance, administration, etc.

"Normal stand-by costs" means having enough extra beds, equipment, supplies, and nursing staff and other staff to take care of any unexpected emergencies or a greater number of patients than usual. Medicare will reimburse providers for such "normal" extras, but it will, ordinarily, not reimburse a provider which claims that an entire unoccupied floor or wing is used for stand-by purposes.

Some other definitions with which you should become familiar are:

Providers of Services (usually referred to as a provider) — A provider of services means a hospital, skilled nursing facility (SNF), home health agency

(HHA) and, for the limited purpose of furnishing outpatient physical therapy or speech pathology services, a clinic, rehabilitation agency or a public health agency.

Participating Provider -- A participating provider is an approved provider of service which has entered into an agreement with HHS:

1. to accept payment based on the reasonable cost of the items and services furnished;
2. not to charge the beneficiary or any other person for Medicare covered items and services, except for allowable charges for deductibles and co-pay amounts;
3. to return any money incorrectly collected.

Hospital for Emergency Services -- An emergency hospital is a nonparticipating hospital which has not entered into an agreement with HHS to participate in the program, but it may receive payment for covered services after complying with the appropriate statutory requirements and regulations. (See the Hospital Manual, HIM-10, Section 202-202.3.)

Federal Provider of Services -- A Federal provider of services may enter into an agreement as a provider only if the Secretary determines that it is providing services to the public generally as a community institution or agency.

Payments for emergency services furnished by Federal hospitals are made through the Office of Direct Reimbursement (ODR) to the appropriate parent Federal agency rather than to the individual hospital. Reimbursement is based on the inpatient and outpatient rates published periodically in the Federal Register by the Office of Management and Budget.

A public health agency is defined in the regulations as "an official agency established by a State or local government, the primary function of which is to maintain the health of the population served by performing environmental health services, preventive medical services, and in certain cases, therapeutic services." (Regulation Subpart Q, Section 405.1702(g).) An example of a public health agency is a neighborhood health center.

Interim Payments

As mentioned before, it would be unfair to make a provider wait for any reimbursement until it has filed its annual cost report. Participating providers are therefore paid interim payments monthly or more frequently on the most expeditious basis administratively feasible. These payments are based on an interim rate that approximates reasonable cost as nearly as practicable. The purpose of interim payments is to maintain a cash flow to the provider during the cost-reporting period.

For cost reporting periods beginning prior to January 1, 1974, providers were paid for services furnished to program beneficiaries on the basis of reasonable cost.

For cost reporting periods beginning after December 31, 1973, payment to providers is made on the basis of the lower of reasonable cost or customary charges made by the provider to the general public for the same services, subject to certain cost limitations.

There are three basic methods used to estimate the amounts of the interim payments. The provider has the option to select any of the three methods. Usually, the provider makes the selection after consultation with its intermediary about the advantages and disadvantages of each method, and taking into consideration its cash flow requirements.

The three basic methods used to estimate the amounts of interim payments are percentage of charges, per diem, and periodic interim payments (PIP).

1. Percentage of Charges

The interim payment is based on a predetermined percentage of the charges made to Medicare patients, e.g., 85 percent of the charges, or 90 percent of the charges. The predetermined percentage is based on the ratio between cost and charges in the hospital.

Deductibles and co-pay amounts billable to the patient are subtracted from the estimated cost to determine the amount payable by the program.

Example: Total charges billed to patient	\$1,200
Less: Charges for noncovered services	<u>200</u>
Total <u>Covered</u> charges	\$1,000
Interim bill rate (predetermined percentage)	90%
Estimated cost of services rendered	\$ 900
Less: Deductible and coinsurance billable to patient	104
Interim amount payable by intermediary	\$ <u>796</u>

This method requires the provider to maintain separate accounting records for each Medicare patient and to submit individual claims forms.

2. Per Diem

The amount of interim reimbursement is based on an estimate of the cost of rendering services on a per day (per diem) basis. Hence, there is no need at the time of the interim payment to account in detail what services the patient received; all that is needed is the number of days the patient received covered services.

Example: Assume a per diem cost of \$150 per day

Total number of covered days during patient stay	8
Estimate of cost of services (\$150 x 8)	\$1,200
Less: deductible and coinsurance billable to the patient	<u>104</u>
Interim payment by intermediary	\$1,096

This method also requires the submittal of individual claims for each Medicare patient.

3. Periodic Interim Payment (PIP)

The theory behind the PIP method is to divide the estimated total cost for the year into regular periodic payments, usually 26, payable in equal amounts on a regular day every other week.

Example: Per diem cost estimate	\$ 155
Total estimated number of covered beneficiary days	2,500
Total estimate of cost of services to be rendered (\$155 x 2,500 days)	\$387,500
Less: estimate of deductibles and coinsurance to be billed to patients	<u>24,000</u>
Estimate of total amount to be paid by intermediary for interim payments	<u>\$363,500</u>
Number of PIP payments	<u>26</u>
Amount of each biweekly PIP payment (\$363,500 ÷ 26)	\$ 13,981

Although individual bills are not required for interim payments under PIP, the provider usually submits them as incurred so that the individual patient's utilization record may be updated.

The PIP method is available to all types of participating hospitals, skilled nursing facilities, and home health agencies meeting these requirements:

- a. Total Medicare payment for inpatient services is at least \$25,000 on an annual basis;

- b. The provider has filed at least one completed cost report under the Medicare program;
- c. The intermediary is satisfied that the provider has the continuing capability of maintaining in its records the cost, charge and statistical data needed to complete a Medicare cost report accurately and timely.

Cost Reports

At the end of the provider's cost reporting period, the provider files its cost report with the intermediary. In order to reimburse the provider as quickly as possible, a tentative adjustment is made as soon as the intermediary has reviewed the cost report. For the purpose of the tentative adjustment, the costs will be accepted as reported except for obvious errors or inconsistencies, subject to a later audit or more intensive review.

After an audit of the cost report or a more intensive review, the intermediary makes necessary adjustments and determines the total allowable cost for the period covered by the cost report and the total reasonable cost reimbursement due the provider. Although it is preferable that the provider agree with the intermediary's adjustments, it is not a requirement for final settlement. The intermediary usually makes every effort to reconcile and adjust any differences with the provider.

After the intermediary has determined the total allowable cost for the period, it subtracts the amount of interim payments made during the period as well as any other monies owed to the program by the provider. The net difference is then paid to the provider if there has been an underpayment, or collected from the provider in the event of an overpayment.

Where there is an overpayment, there are several ways in which repayment can be made. In some cases, the provider may be able to refund the entire amount in a lump-sum payment; in others, a schedule of repayments may be the most feasible way to repay. There will be some cases where some sort of set-off is the only way to repay the money owed; e.g., withholding given amounts of money from interim payments; or there may be a combination of partial repayment and the remainder through set-off.

Where a provider fails to file a cost report, the intermediary sends the provider a notice that the interim rate will be reduced, effective 30 days from the date of notice.

If the intermediary does not receive the cost report or a response to the first demand letter within 30 days, the intermediary adjusts the interim rate immediately and sends the provider a second demand letter notifying the provider of the reduction. The letter also informs the provider that the intermediary will refer the case to the regional office for Health Care Financing Administration collection, if the provider does not take appropriate action. A copy of this letter is sent to the HCFA RO.

The intermediary contacts the provider about seven days after mailing the second demand letter, to ascertain (1) whether the provider is having problems in preparing the cost report, and (2) whether, and when, the provider expects

to submit the cost report. The intermediary documents the provider's response for the record. If the provider does not submit the cost report or responds to the second demand letter within 30 days from the date of the second demand letter, the intermediary will suspend all payments immediately.

If the provider does not respond or submit a cost report by the 30th day from the date of the second demand letter, the intermediary sends the provider a third demand letter informing the provider that all payments have been suspended and that continued failure to respond may result in termination of the agreement (if the overpayment is \$1,000 or more); and that interest will be assessed if it becomes necessary to sue in a court of law. The intermediary also urges the provider to respond to the third demand letter within 21 days to avoid Health Care Financing Administration or Department of Justice involvement. A copy of this letter is sent to the HCFA regional office.

If no response is received to the third demand letter within 30 days, the intermediary refers the overpayment to the HCFA RO for necessary action.

However, should the provider thereafter submit an acceptable cost report, the intermediary notifies the regional office and undertakes the necessary audit activities.

Cost reports are filed annually covering a 12-month period of operations based on the provider's accounting year.

Cost reports are due on or before the last day of the third month following the close of the period covered by the report. (A 30-day extension of the due date may be granted by the program for good cause.)

Where a hospital or hospital-based SNF or a hospital-based HHA submits a certified cost report that has been audited by the hospital's independent auditors, the cost reports are due on or before the last day of the fourth month following the close of the period covered by the report.

Where the provider terminates from the program either voluntarily or involuntarily, or there has been a change of ownership, the cost reports are due no later than 45 days following the effective date of termination or change of ownership.

The provider may select any annual period for Medicare cost reports regardless of the reporting period it uses for other programs. Once a provider has made a selection and reported accordingly, the provider is required thereafter to report each year for periods ending as of the same date, unless the intermediary approves a change in the provider's reporting period. The approval for the change must be authorized in writing by the intermediary.

The provider's written request for a change in the cost reporting period must be received by the intermediary 120 days or more before the close of the reporting period which the change proposed to establish. Such a change may be made only after the intermediary is satisfied that the reason for the change is consistent with the purposes and intent of the program. A change which is made primarily to maximize reimbursement in any one period would not be acceptable.

A provider may choose any one of the following types of reporting periods, but it must continue to use the same type consistently in subsequent years:

1. 12 successive calendar months;
2. 13 four-week periods with an additional day added to the last week or period to make it coincide with the end of the calendar year or month;
3. A reporting period which will vary from 52 to 53 weeks because it must always end on the same day of the week (Monday, Tuesday, etc.).

A new provider may select an initial cost reporting period of at least one month but not to exceed 13 months.

For example, a new provider which starts with the Medicare program on September 17, 1979, and wishes to adopt a reporting period ending on September 30, must file a report for the entire period from September 17, 1979 to September 30, 1980. The provider is not permitted to file a cost report for the 13 days from September 17 to September 30, 1979.

When a provider ceases to participate in the health insurance program, it must file a report covering a period under the program up to the effective date it stopped participating in the program. Depending on the circumstances involved in the preparation of the provider's final cost report, the provider may file the cost report for a period of not less than one month and not more than 13 months.

When a hospital or skilled nursing facility (SNF) terminates its participation in the health insurance program, either voluntarily or involuntarily, the hospital or SNF may continue to be reimbursed for covered Part A inpatient services for up to 30 days after the effective date of termination. This reimbursement applies only to Medicare patients who were admitted before the termination date. No reimbursement will be made for such services to patients admitted on or after the termination date.

No payment will be made for hospital services to outpatients or for outpatient physical therapy or speech pathology services furnished by a provider on or after the effective date of termination.

Payment can continue to be made to home health agencies for covered Part A and Part B home health services furnished through the calendar year in which the termination is effective where the plan of treatment was established prior to the date of termination.

Payment for allowable covered services after the provider has stopped participating in the program will be made at an interim rate based on the latest cost report submitted by the provider. Settlement for such services will be on the basis of a per diem rate developed from Medicare data appearing in the provider's final cost report.

No cost report will be required for the services furnished following cessation.

A provider that has not furnished any covered services to Medicare beneficiaries during the entire cost reporting period need not file a full cost report.

The provider must submit to its intermediary a statement, signed by an authorized provider official, which identifies the reporting period to which the statement applies and states:

1. No covered services were furnished during the reporting period; and
2. No claims for Medicare reimbursement will be filed for this reporting period.

The statement must be accompanied by a completed first page of the applicable cost report form and must be submitted within 30 days following the close of the reporting period.

Where a provider has had low utilization of covered services by Medicare beneficiaries in a reporting period and received correspondingly low interim payments, the intermediary may authorize less than a full cost report. The intermediary's decision should be based on its knowledge of the provider's Medicare utilization and the interim payments made to the provider.

However, the intermediary may require full cost reporting and auditing if it is necessary to serve the best interests of the program, regardless of low Medicare utilization or the amount of interim reimbursement.

Chain organizations are not permitted to file a combined or consolidated cost report under the Medicare program. (The only exception under this rule applies to State health department home health agencies with subunits or branches, who are permitted to file a combined cost report under the 7800 series of provider numbers.)

Multiple-facility-complex providers, i.e., hospitals with hospital-based skilled nursing facilities or with hospital-based home health agencies must file a single cost report for the entire complex. For periods prior to July 1, 1978, the cost report form used depended upon the bed size of the entire complex, i.e., whether it had less than 100 beds or 100 or more beds.

New Providers

Before any program payments can be made to a newly participating provider, the intermediary must review the provider's fiscal and other records to assure that the provider has an adequate ongoing system for furnishing accurate cost data and other information for cost reporting purposes. The cost data and other information must be capable of verification by qualified auditors. The intermediary must also look into possible transactions with related organizations or any self-dealing with owners, franchisors, management consultants, etc.

These reviews are supposed to be made periodically by the intermediary. Special attention is paid to the continuing recordkeeping capability of the provider, especially where there is a large overpayment, or where a change of ownership has occurred, or there is a possibility of the provider's bankruptcy.

Hearings and Appeals

After the intermediary has completed the final review of the cost report and made all the necessary adjustments, it sends the provider a written Notice of Program Reimbursement (NPR). The NPR sets forth the adjustments made by the intermediary, the final adjusted amounts and the amount of overpayment or underpayment.

If the NPR is issued on an unaudited cost report (i.e., not audited by the intermediary), it includes a notice that the cost report is subject to revision during the three-year period following the date of the NPR, if such a revision is required by the findings of an audit started within this three-year period. In other words, the provider is notified that if a subsequent audit, started within the three-year period results in adjustments which affect the year covered by the NPR, then the intermediary will reopen that year.

The NPR also advises the provider of its right to a hearing on disputed items in the cost report. The hearing can be an intermediary hearing or a Provider Reimbursement Review Board (PRRB) hearing, depending on the cost reporting period involved and on the amount in controversy.

For cost reporting periods ending June 30, 1973, or later, a provider (or group of providers where the matters in controversy involve common questions of fact or common provision of the law or regulations) which is dissatisfied with the intermediary's adjustments and final amount of reimbursement may request a PRRB hearing when:

1. The amount of Title XVIII controversy is \$10,000 or more; or
2. \$50,000 or more for a group of providers.

If the amount in controversy is less than \$10,000, but at least \$1,000 or more, the provider may request an intermediary hearing.

For cost reporting periods ending after December 31, 1971, but before June 30, 1973, a provider could request an intermediary hearing when the amount in controversy was at least \$1,000. There was no maximum limit. (The Provider Reimbursement Review Board was not in existence prior to 1973.)

An intermediary hearing is conducted by a hearing officer or a panel of hearing officers designated by the intermediary.

Intermediary hearing officer decisions are subject to review by HCFA either on its own motion or at the request of the provider under certain conditions. Providers may not request HCFA review of a hearing officer's decision when the disagreement is based on the factual situation rather than on the way regulations or instructions were implemented. In such factual situations, the provider should request the hearing officer to reopen the decision.

A Provider Reimbursement Review Board hearing is conducted by the Board, whose members are appointed by the Secretary of HHS.

Decisions made by the Provider Reimbursement Review Board are final and binding on all parties to the hearing, unless:

1. The decision is reviewed and affirmed, reversed, or modified by the Secretary; or
2. The decision is reopened and revised within three years by the Board; or
3. The provider appeals to the Federal courts.

A provider has the right to judicial review of any PRRB decision or any subsequent affirmation, modification or reversal by the Secretary.

CHAPTER 5

COSTS RELATED TO PATIENT CARE

Prudent Buyer Principle

Costs Not Related to Patient Care

Visiting Costs of Home Health Agencies

Services Furnished Under Arrangements

Costs of Drugs and Related Medical Supplies

Research Costs

Dental Services

Telephone, Television and Communication Systems

Parking Lots

Billing Costs

Orientation and On-The-Job Training

Fringe Benefits

Governmental Providers

Costs Incurred After Provider Terminates Participation in the Program

COSTS RELATED TO PATIENT CARE

As we have said a number of times previously, all payments to providers must be based on the reasonable cost of services furnished for the care of Medicare patients. Reasonable cost includes all necessary and proper costs incurred in rendering the services.

Reasonable cost takes into account all costs of providers of services. The objective is that under the methods of determining costs, "the costs with respect to individuals covered by the program will not be borne by others not so covered, and the costs with respect to individuals not so covered will not be borne by the program."

Implicit in the intention that actual costs be paid to the extent they are reasonable, is the expectation that the provider will seek to minimize its costs and that its actual costs will not exceed what a prudent and cost-conscious buyer would pay for a given item or service. If costs exceed a reasonable level, the excess costs are not reimbursable under the program, unless there is clear evidence that the higher costs were unavoidable.

The prudent and cost-conscious buyer not only refuses to pay more than the going price for an item or service, he or she also seeks to economize by minimizing cost. This is especially so when the buyer is an institution or organization which makes bulk purchases and can, therefore, often gain discounts because of the size of its purchases. In addition, bulk purchase of items or services often gives the buyer leverage in bargaining with suppliers for other items or services. An alert and cost-conscious buyer seeks such advantages, and it is expected that Medicare providers of services will also seek them.

Examples of Application of the Prudent Buyer Principle

1. Provider A consistently purchases supplies from supplier R and makes no effort to obtain the most advantageous price for its supplies. Supplier W sells identical or equivalent supplies at a lower cost and is also convenient to A. Unless the provider can clearly justify its practice of purchasing supplies from R rather than W, the intermediary should exclude any excess of R's charges over W's charges.
2. Dr. C, a hospital-based radiologist, purchases radiology equipment which he then leases to the provider where he is a staff member. Costs to the provider in this case are higher than if the equipment had been leased through competitive bidding from an outside source. The intermediary should reimburse the provider only for those costs which a prudent and cost-conscious buyer would pay. Therefore, those costs which the provider pays for the equipment leased from the staff radiologist which are in excess of costs for equivalent equipment obtained through competitive bidding should be denied.

Cost related to patient care include all necessary and proper costs which are appropriate in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care usually include costs such as depreciation, interest expense, nursing costs,

maintenance costs, administrative costs, costs of employee pension plans, normal standby cost and others.

Costs not related to patient care are costs which are not appropriate or necessary in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. They include, for example, costs of meals sold to visitors, costs of drugs sold to other than patients, cost of operation of a gift shop, and similar items.

There are some costs which are related to patient care but are not allowable costs. For example:

The costs of private-duty nurses and other private duty attendants are not included in allowable costs. Services of private nurses and attendants are specifically excluded from coverage by law.

The cost of ambulance service is reimbursed under the supplemental medical insurance plan, Part B, and therefore these costs must be removed from the provider's costs under Part A.

A provider may furnish ambulance services either directly or under agreements. Where a provider furnishes ambulance services to program beneficiaries, reimbursement is made on a reasonable cost basis. When the services are provided under arrangements, the charge to the provider by the ambulance company becomes the provider's cost. This charge must be reasonable and the cost to the provider should not exceed the amount established as reasonable for such services by the Medicare Part B carrier serving the same locality. In any event, the cost should not exceed the amount the ambulance company would have been permitted to charge the program directly.

Where provider operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs. Luxury items or services are those that are substantially in excess of or more expensive than the usual items or services rendered within a provider's operation to the majority of patients. Examples of luxury items or services are given below.

Luxury room accommodations are usually significantly larger in size than the usual size of a room in the hospital or skilled nursing facility. The luxury room may have a special bed and a refrigerator and more lavish bathing accommodations. The room charges are generally higher than the rates charged by the provider for its usual rooms.

Luxury food items are indicated by the maintenance of a separate kitchen for the preparation of special foods and separate menus for selected patients. (Special diets ordered by a patient's physician or that permit a patient to continue with his or her already established dietary habits required for good cause are not considered luxury food items.)

Once it has been determined that luxury items or services have been furnished, allowable costs must be reduced by the difference between the costs of luxury items or services actually furnished and the reasonable costs of the usual less expensive items or services furnished by a provider to the majority of its patients. Where patients request luxury items or services, the provider may charge the patients for the excess costs involved.

Where a provider furnishes luxury items or services to all patients in the facility, the provisions of this section do not apply. Instead, the provision dealing with limitations on coverage of costs (Section 223)* must be applied to such a provider. Also, for purposes of applying the limitation of program reimbursement to the lower of reasonable costs or customary charges (Section 233)*, reasonable costs do not include the excess costs of luxury items or services and customary charges do not include the portion of the charges applicable to the excess cost of luxury items or services.

* 1972 Amendments to Social Security Act.

The following sections describe in general terms Medicare costs which are reimbursable to the provider and costs which are not reimbursable.

VISITING COSTS OF HOME HEALTH AGENCIES

Costs related to patient care visits are allowable home health agency costs. Visiting costs are incurred when a staff member of the home health agency or others under arrangements made by the home health agency make a personal contact to provide a covered home health service to a patient in his place of residence.

Visiting costs include all incurred costs related to making the visits, such as preparation for the visits, telephone calls or conferences about the patients, maintaining the patients' records, travel to the patients, and treating the patients.

Such costs are also covered if the patient has to go to a hospital, skilled nursing facility, rehabilitation center, or outpatient department affiliated with a medical school as an outpatient to receive covered home health services which involve the use of equipment which is not available to the patient in his place of residence.

NONVISITING COSTS OF HOME HEALTH AGENCIES

Nonvisiting costs are not allowable costs under Medicare. Nonvisiting costs are costs related to activities of the home health agency other than home visiting or visits by the patients as an outpatient to a hospital, skilled nursing facility, rehabilitation center, or outpatient department affiliated with a medical school for covered home health services. Examples of nonvisiting costs include costs incurred for the operation of school visit programs, meals-on-wheels programs, well-baby clinics, etc.

Payments to physicians for their direct medical services to individual patients are not allowable home health agency costs.

COSTS OF SERVICES FURNISHED UNDER ARRANGEMENTS

Providers may furnish services under arrangements with outside suppliers, including other providers. For example, many providers arrange to have physical therapy, respiratory therapy, or speech therapy furnished to patients by outside suppliers. Other providers may make arrangements for ambulance services with an outside supplier, and some providers which do not have their own pharmacy purchase drugs under arrangements with local pharmacies.

The amount charged by the supplying organization and paid by the provider for the services rendered then becomes a cost to the provider. This amount is includable in the provider's allowable costs for Medicare purposes to the extent that the costs of such purchased services are determined to be reasonable, subject to the provisions of Chapter 10, PRM, Cost to Related Organizations.

The services are treated as though they were furnished directly by the provider. Where services are provided under arrangements, the supplier bills the provider and is paid by the provider for the services actually rendered. Under these circumstances, the Medicare program cannot directly reimburse the

supplier of services. Payment for such services is made as a part of provider costs. Provider cost in this instance is limited to the net amount actually paid the supplier. If the provider imposes a charge for billing services or other administrative services on the supplier, such amount must be treated as a discount to the provider.

The costs of items purchased under arrangements that are considered as a part of covered routine inpatient services are includable in the provider's overall allowable cost for routine services. The costs of routine services will then be apportioned over all patients in accordance with the apportionment method selected. The provider should not bill the program for these purchased services on an individual patient basis, even though the service is actually secured for a specific patient.

When ancillary services are purchased under arrangements, the supplier should bill the provider for the services which are actually rendered, itemizing such services by individual patient, the date of service and, where appropriate, the related charge for each service and the quantity of service provided. This bill provides the supporting documentation for the cost to be included in the provider's allowable cost. The detailed information is used by the provider to bill the Medicare program for the services provided to each Medicare patient.

While charges for equivalent services of a supplier of services under arrangements must be uniform for Medicare and non-Medicare patients, billing practices of such a supplier need not be identical for both Medicare and non-Medicare patients. The supplier may bill non-Medicare patients directly although the supplier is not permitted to bill Medicare patients directly. Only the provider may bill the Medicare program for services furnished to Medicare patients.

Where a supplier furnishes services under arrangements only for Medicare beneficiaries and bills directly for non-Medicare patients, the costs of such non-Medicare services should not be commingled with other provider costs. Rather, the cost of such services should be included in total Medicare costs after cost finding and apportionment.

COSTS OF DRUGS AND RELATED MEDICAL SUPPLIES

The costs of drugs and related medical supplies furnished by providers to Medicare beneficiaries is reimbursed by the program on a reasonable cost basis. To meet the test of reasonableness, the cost of the drug or related medical supply may not exceed the amount a prudent and cost-conscious buyer would pay for the same item.

In July 1975, the Department of Health and Human Services (HHS) announced new regulations, effective August 1976, for reimbursing pharmaceutical services under Medicare, Medicaid, and other departmental health programs. Known as the Maximum Allowable Cost (MAC) regulations, they are designed to save money by taking advantage of competition among manufacturers and of price differences resulting from the purchasing power of providers.

Until the MAC regulations, HHS programs generally reimbursed providers for whatever was charged by the marketer of the brand dispensed, even though other brands of the same drugs were available at lower prices. To save money by

taking advantage of price differences among brands of the same drug, HHS established a Pharmaceutical Reimbursement Board to identify the lowest price at which a drug is widely and consistently available. This price becomes the highest price reimbursable. The first price ceiling, on 250 mg and 500 mg ampicillin capsules took effect June 27, 1977.

This maximum allowable cost limitation, called the "MAC" for a particular drug, is based on the lowest unit price at which the drug is widely and consistently available to pharmacists from any formulator or labeler, and in the most frequently purchased package size. An example of some MAC determinations is included at the end of this section. The listing includes the MAC limitation and its effective date, the generic name of the drug, and a list of the most frequently purchased brand names of the drug.

For purchases made on or after the effective date of the final MAC determinations, the allowable cost for any multiple-source drug for which a MAC has been established may not exceed the lowest of:

- (1) the actual costs,
- (2) the amount which would be paid by a prudent and cost-conscious buyer for the drug if obtained from the lowest priced source that is widely and consistently available within a provider's service area, whether sold by generic or brand name, or
- (3) the MAC.

Outpatient programs, such as Medicaid, have usually based reimbursement on the list price of the product plus a dispensing fee. Beginning in August 1976, reimbursement to pharmacies is based on an estimated acquisition price (EAC) of the actual price paid by the provider, plus a fee related to the cost of filling the prescription. HHS provides data to the State agencies to help them make estimates.

PRESCRIPTION DRUGS

Providers which have their own pharmacy are expected to purchase drugs in bulk, where possible, from manufacturers or recognized wholesale outlets to gain economics from quantity purchasing.

Providers not having their own pharmacies generally purchase drugs under arrangements with local pharmacies rather than from manufacturers or wholesalers. Where the drugs are purchased under arrangements, the charges to the provider by the supplier become the provider's pharmacy costs. In such cases, these providers should pay no more than the going rate for prescription drugs and, in addition, should seek to minimize their pharmacy costs by obtaining discounts, either direct or indirect, from the supplier. It is not expected that a provider will utilize the services of a higher charge pharmacy for its normal prescription needs merely because the pharmacy provides 24-hour emergency services. (Of course, the Medicare program will recognize the costs of services from a pharmacy furnishing 24-hour services when a prescription is required at a time when the provider's normal source of prescription is not available, even though this pharmacy may have higher charges than and may not be the same as the one with which the regular prescription orders are placed.)

EXCEPTION TO THE MAC LIMIT

The MAC limit for a particular drug will not apply where a physician certifies that in his medical judgment a specific brand name drug is medically necessary for an individual patient. The individual patient's name and the particular drug prescribed must be clearly identifiable. This certification must be in the physician's own handwriting. Merely checking a box on a form or stamping a prescription will not be considered an acceptable certification. Written certifications must be retained in the provider's records. This exception, however, does not waive the requirement that the cost of the drug may not exceed the amount a prudent and cost-conscious buyer would pay for the drug prescribed.

Nonprescription Drugs and Medical Supplies -- Wherever feasible and to the extent permitted by State law, providers should also purchase their nonprescription drugs and medical supplies in bulk to get more reasonable prices and take advantage of quantity and other discounts. Any cost reductions received on drug purchases, such as discounts (cash, trade, purchase and quantity), rebates, etc., must be clearly reflected on the individual invoices or related documentation.

Charges to Beneficiaries -- If the amount determined to be allowable is less than the amount charged the provider by an outside supplier, the Medicare patient cannot be charged for the excess. The provider's agreement with the Secretary prohibits charging the Medicare patient for covered items and services (Section 1866(a)(1)(A) of the Social Security Act).

Example: (This example is from the PRM, Section 2119.) Invoice shows the provider purchased from a recognized wholesale outlet a widely distributed brand name version of drug X, as follows:

Assume the MAC for drug X, 250 mg. capsules, is set at 2.2 cents/capsule. 100 bottles, 100 capsule size @ \$3.90 per bottle.

Total invoice price	\$ 390
Deduct:	
Total maximum allowable cost	
(2.2 cents x 100 x 100)	- 220
Excess =	\$ 170

The \$170 excess above the MAC amount will be deducted from the provider's total allowable drug costs.

The following list is an example of Maximum Allowable Cost (MAC) Determinations for Drugs. These lists can be found in the Appendix to Chapter 21 in the PRM.

Maximum Allowable Cost (MAC) Determinations for Drugs

<u>Drug</u>	<u>Strength</u>	<u>MAC</u>	<u>Effective Date</u>
*Acetaminophen w/codeine	30 mg.	\$0.0780 per tablet	January 25, 1979
*Acetaminophen w/codeine	60 mg.	\$0.1545 per tablet	January 25, 1979

The most common brand names of these two strengths of Acetaminophen w/codeine are:

Empracet w/codeine
Tylenol w/codeine

*The MACs for Acetaminophen w/codeine do not apply to unit dose packaging.

Amoxicillin capsules	250 mg.	\$0.2108 per capsule	June 28, 1979
Amoxicillin capsules	500 mg.	\$0.3942 per capsule	June 28, 1979

The most common brand names of these forms and strengths of Amoxicillin are:

Amoxil Larotid Polymox

[The MACs for Amoxicillin do not apply to unit dose packaging.]

Ampicillin capsules	250 mg.	\$0.0725 per capsule	June 27, 1977 through January 24, 1979
*Ampicillin capsules	250 mg.	\$0.0595 per capsule	January 25, 1979
Ampicillin capsules	500 mg.	\$0.1390 per capsule	June 27, 1977 through January 24, 1979
*Ampicillin capsules	500 mg.	\$0.1103 per capsule	January 25, 1979

<u>Drug</u>	<u>Strength</u>	<u>MAC</u>	<u>Effective Date</u>
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The most common brand names of these two strengths of Ampicillin capsules are:

Alpen	Ampifort	Penbritin	QID Amp
Amcill	Amplin	Pensyn	SK-ampicillin
Amp-D	Omnipen	Polycillin	Supen
Ampi Co	Pen-A	Principen	Totacillin

*Effective January 25, 1979, the MACs for these two strengths of Ampicillin do not apply to unit dose packaging.

Ampicillin oral suspension	125 mg./ 5 ml.	\$0.0145 per ml.	October 25, 1977
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Ampicillin oral suspension	250 mg./ 5 ml.	\$0.0205 per ml.	October 25, 1977
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The most common brand names of these two strengths of Ampicillin oral suspension are:

Alpen	Pen-A	Polycillin	Supen
Amcill	Penbritin	Principen	Totacillin
Omnipen	Pensyn	SK-ampicillin	

Chlordiazepoxide HCL capsules	5 mg.	\$0.0270 per capsule	May 12, 1978
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Chlordiazepoxide HCL capsules	10 mg.	\$0.0378 per capsule	May 12, 1978
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Chlordiazepoxide HCL capsules	25 mg.	\$0.0640 per capsule	May 12, 1978
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The most common brand names of these strengths of Chlordiazepoxide are:

Diazachel	Librium	SK-Lygen
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*Doxepin HCL	10 mg.	\$0.0950 per capsule	January 25, 1979
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*Doxepin HCL	25 mg.	\$0.1161 per capsule	January 25, 1979
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*Doxepin HCL	50 mg.	\$0.1765 per capsule	January 25, 1979
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The most common brand names of these strengths of Doxepin are:

Sinequan	Adapin
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*The MACs for Doxepin HCL do not apply to unit dose packaging.

<u>Drug</u>	<u>Strength</u>	<u>MAC</u>	<u>Effective Date</u>
*Erythromycin Stearate	250 mg.	\$0.0697 per tablet	January 25, 1979
*Erythromycin Stearate	500 mg.	\$0.1250 per tablet	January 25, 1979

The most common brand names of these strengths of Erythromycin Stearate are:

Erythrocin Stearate	Ethril	Pfizer-E
Bristamycin	SK-Erythromycin-S	

*The MACs for Erythromycin Stearate do not apply to unit dose packaging.

*Hydrochlorothiazide	25 mg.	\$0.0250 per tablet	June 28, 1979
*Hydrochlorothiazide	50 mg.	\$0.0306 per tablet	June 28, 1979

The most common brand names of these strengths of Hydrochlorothiazide are:

Aldactazide	Esidrix	Hydrodiuril
Butizide	Serpasil	Oretic

*The MACs for Hydrochlorothiazide do not apply to unit dose packaging.

*Meprobamate	200 mg.	\$0.0108 per tablet	January 25, 1979
*Meprobamate	400 mg.	\$0.0117 per tablet	January 25, 1979

The most common brand names of these two strengths of Meprobamate are:

Miltown	Equanil	Mepro tabs
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*The MACs for Meprobamate do not apply to unit dose packaging.

Penicillin VK oral suspension	125 mg./ 5 ml.	\$0.0120 per ml.	October 25, 1977
Penicillin VK oral suspension	250 mg./ 5 ml.	\$0.0160 per ml.	October 25, 1977
Penicillin VK tablets	250 mg.	\$0.0535 per tablet	October 25, 1977
Penicillin VK tablets	500 mg.	\$0.1025 per tablet	October 25, 1977

<u>Drug</u>	<u>Strength</u>	<u>MAC</u>	<u>Effective Date</u>
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The most common brand names of these forms and strengths of Penicillin VK are:

Beta-pen VK	Ledercillin VK	QID Pen VK	SK-Penicillin VK
Compocillin VK	Penapar VK	Repen VK	Uticillin VK
Deltapen VK	Pen-Vee K	Robicillin VK	V-Cillin K
Kesso-pen VK	Pfizerpen VK	Ro-Cillin VK	Veetids

*Phenylbutazone	100 mg.	\$0.0750 per capsule	January 25, 1979
*Phenylbutazone Alka	100 mg.	\$0.0940 per capsule	January 25, 1979

The most common brand names for these forms and strength of Phenylbutazone are:

Butazolidin

Butazolidin Alka

*The MACs for Phenylbutazone and Phenylbutazone Alka do not apply to unit dose packaging.

*Probenecid	0.5 gm.	\$0.0644 per tablet	January 25, 1979
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The most common brand names of this strength of Probenecid are:

Benemid

Probalan

*The MACs for Probenecid do not apply to unit dose packaging.

*Propoxyphene HCL capsules	65 mg.	\$0.0317 per capsule	April 24, 1978
*Propoxyphene HCL with APC capsules	65 mg.	\$0.0330 per capsule	April 24, 1978

The most common brand names of these forms and strength of Propoxyphene are:

Darvon

Dolene

SK-65

*The MACs for Propoxyphene HCL and Propoxyphene HCL with APC do not apply to unit dose reverse number strip packaging for institutional use.

<u>Drug</u>	<u>Strength</u>	<u>MAC</u>	<u>Effective Date</u>
Tetracycline HCL capsules	250 mg.	\$0.0250 per capsule	April 10, 1978
Tetracycline HCL capsules	500 mg.	\$0.0465 per capsule	April 10, 1978

The most common brand names of these strengths of Tetracycline are:

Achromycin V	Cyclopar	Robitet	Tetracyn
Amtet	Panmycin	SK Tetracycline	Tetram
Bristacycline	Retet	Sumycin	

* U.S. Government Printing Office: 1979-665-077/5140

* Appeals — A provider may appeal the amount of program reimbursement made for drugs in accordance with the requirements and procedures described in PRM Section 2425ff. However, the provisions of Section 2425ff do not apply to disputes concerning the inclusion of a specific drug. For disputes involving these issues, provisions of the Department's MAC regulations shall apply.

Appeals -- A provider may appeal the amount of program reimbursement made for drugs in accordance with the requirements and procedures described in PRM Section 2425ff. However, the provisions of Section 2425ff do not apply to disputes concerning the inclusion of a specific drug. For disputes involving these issues, provisions of the Department's MAC regulations shall apply.

RESEARCH COSTS

For Medicare purposes, research means a systematic, intensive study directed toward a better scientific knowledge of the science and art of diagnosing, treating, curing and preventing mental or physical disease, injury, or deformity; relieving pain; and improving or preserving health. Research may be conducted at a laboratory bench without the use of patients or it may involve patients. Furthermore, there may be research projects that involve both laboratory bench research and patient care research.

Care rendered to research patients is usually not necessarily medically required or ordinarily furnished to patients, and often results in extra costs for the Medicare program. Even though research costs are not included in Medicare reimbursement, it should be noted that medical and hospital research has always been generously supported by the Federal government through other programs.

Usual patient care is the care which is medically reasonable, necessary, and ordinarily furnished in the treatment of patients by providers under the supervision of physicians as indicated by the medical condition of the patients. In the context of this principle, extraordinary patient care is the care rendered to research patients which is not medically reasonable, necessary, or ordinarily furnished to patients by providers. Such care is represented by additional patient care days and additional ancillary charges identified as non-Medicare in the patient care cost centers.

Costs of research are not reimbursable to providers. Where, however, research is conducted in conjunction with or as part of the care of patients, the costs of usual patient care are reimbursable to the extent such costs are not met by research funds. The costs of extraordinary patient care based on research objectives are not reimbursable.

Usual patient care costs incurred in conjunction with the research must be specifically identified in those situations where a portion of the research funds is applicable to usual patient care costs. Providers must maintain statistics on research patients for each research project to identify the patients and the patient days and ancillary charges applicable to the usual patient care furnished by providers.

Where research funds are received by a provider to finance usual patient care in conjunction with the research, the amount of the research funds designated for usual patient care is used as an offset to the costs of the applicable patient care cost centers.

NOTE: If the research grant requires that any excess research funds for usual patient care costs must be returned to the grantor or donor, providers are not required to offset these excess funds against allowable patient care costs. (See Section 505 ff in the Provider Reimbursement Manual for specific details on determination of research funds applicable to patient care.)

Studies, analyses, surveys, and related activities aimed at improving and making provider administration and operation more efficient are not considered research costs, but are includable in allowable administrative costs.

A separate cost center for research is usually established in the provider's accounting records. Direct research costs such as employees' salaries, materials, supplies, contractual services, etc., are charged directly to the research cost center. Indirect costs such as administrative expenses, employee fringe benefits, maintenance, operational expenses, etc., are allocated to the research cost center through the cost-finding process.

Dental Services

Compensation paid to a dentist for services to or for an individual patient are not allowable provider costs and are nonreimbursable to the provider. The costs, however, of consultative services furnished by an advisory dentist to a provider are allowable costs, subject to the usual rules concerning reasonable costs incurred by providers. Consultative services may include, for example, participating in the staff development program for nursing and other personnel and recommending policies relating to oral hygiene or dietary matters.

Telephone, Television and Communication Systems

The full costs of items or services such as telephone, television, and radio which are located in patient accommodations and which are furnished solely for the personal comfort of the patients are not includable in allowable costs of providers under the Medicare program. To illustrate, the full costs of telephones used solely for the personal comfort of patients include not only costs directly associated with these telephones, such as the rates billed by the public utility, but also an appropriate share of indirect telephone costs; e.g., operators' salaries, equipment, space related costs of switchboard and other equipment, etc., as well as any other overhead costs that may be applicable thereto.

The costs of television and radio services are includable in allowable costs where furnished to the general patient population in day rooms, recreation rooms, waiting rooms, lounges, etc., but not in patients' rooms.

The cost of a nurse-patient communication system that has no capability for other than communications between patient and nurse (or other facility employees) is includable in allowable costs. Similarly, costs of closed circuit television monitoring systems used by providers for surveillance of patients or for security, teaching, or demonstration programs which serve purposes of patient care or which are otherwise needed for the provider's operations and have no capability beyond these stated purposes are includable in allowable costs.

Some nurse-patient communication systems based on closed circuit television are used in part for bringing in outside entertainment. Likewise, some patient communication systems operate through the telephone line and such a system may also be used, in part, by the patient for making or receiving outside calls. Where providers use the combined systems, the basic cost of the components designed and used for patient care communication will be an allowable cost. Any incremental costs attributable to the additional components or capability for providing the patient's entertainment or convenience are not allowable and must be excluded. Where this distinction cannot be clearly made, particularly as it applies to maintenance, the intermediary may approve an allocation covering these incremental costs based on an equitable sharing.

Parking Lots

The cost incurred for provider-owned or rented parking facilities, parking lots, and/or garages are allowable costs provided the parking facilities are for the use of patients, visitors, employees, and other provider purposes. Examples of allowable costs for a provider-owned parking facility include depreciation on the surface and structure (excluding land), interest on related loans, and other operating expenses. Costs related to the preparation of the land such as demolition of existing structures, clearing, and grading costs should be added to the cost of the land and are unallowable.

Where a provider receives no revenue from parking lots, the allowable costs are reimbursed, subject to apportionment. Where, however, a provider elects to charge a fee for the use of these facilities, such revenue is treated under Medicare as follows:

Where parking revenue is received from persons other than employees and physicians, the revenue is offset against parking lot costs attributable to such persons. If parking revenue exceeds the related costs, the excess revenue is not used to reduce employee and physician parking costs (or other provider costs) so long as the provider can demonstrate a reasonable and equitable basis for allocating parking costs between (1) employees and physicians, and (2) other persons. Where such an allocation is not determinable, the total allowable cost of provider-owned or rented parking facilities should be reduced by all parking facility revenue.

Revenue from employees and physicians for parking must be used to reduce related allowable parking costs. If employee and physician parking revenue exceeds related costs (i.e., parking costs for employees and physicians), any excess revenue is applied against other parking costs, but not against other allowable costs.

BILLING COSTS

Billing costs generally include all costs related to charging patients for the services they received. These costs include preparing bills, keeping records of accounts receivable and collections, followups on delinquent accounts, costs of collection agencies, etc.

In the cost finding process, billing costs are generally allocated to the various cost centers as part of administrative costs. Medicare reimburses providers for its proportionate share of these costs as determined in the apportionment of the costs of the various cost centers.

Where a provider contracts for billing services to be performed by another organization, the contract costs of such services are allowable costs unless the billing organization is related to the provider. Then the billing costs are subject to the provisions of PRM Chapter 10, Cost to Related Organizations.

These costs are administrative costs and are subject to cost allocation and apportionment even though the billings contracted out are Medicare billings. This means that the cost of the outside billing services are allocated to all patients even though only Medicare billings were prepared by the outside organization.

Where a provider derives income from interest, finance charges or penalties on delinquent accounts receivable, the actual cash received must be used as a deduction from allowable administrative and general costs.

Where a provider imposes a charge for billing or any other administrative services on a supplier of services furnished under arrangements, the amount of the charge is treated, for Medicare purposes, as a discount for the services rendered. It may not be considered as income from billing or other administrative services. Accordingly, the amount of allowable cost for any service furnished under arrangements is the net amount paid by the provider.

ORIENTATION AND ON-THE-JOB TRAINING

The costs of orientation and on-the-job training are recognized as normal operating costs and are allowable. Ordinarily, such training would be given within the provider setting. If, however, the training requires outside instructions, costs of such training are allowable.

Vocational and Scholastic Training Expense -- The costs attributable to vocational, scholastic, or similarly oriented training activities conducted by providers on behalf of patients are not allowable costs. For example, costs incurred by a psychiatric facility in operating an elementary or secondary school for patients are unallowable costs.

FRINGE BENEFITS

Fringe benefits are amounts paid to, or on behalf of, an employee, in addition to direct salary or wages, and from which the employee or his or her beneficiary derives a personal benefit before or after the employee's retirement or death.

Fringe benefits inure primarily to the benefit of the employee. However, there may also be some intrinsic benefit to the provider, such as increasing employee work efficiency and productivity, reducing personnel turnover, or increasing employee morale.

The costs of fringe benefits must be reasonable, and related to patient care.

Medicare recognizes the following fringe benefits:

1. provider contributions to certain deferred compensation plans;
2. provider contributions to certain pension plans;
3. paid vacation or leave, paid holidays, paid sick leave, voting leave, court or jury duty leave, all of which generally are included in employee earnings;
4. provider paid educational courses benefiting the employee's interest;
5. provider's unrecovered cost of meals and room and board furnished employees for their convenience;

6. provider's unrecovered cost of medical services rendered to employees;
7. cost of health and life insurance premiums paid or incurred by the provider if the benefits of the policy inure to the employee or his/her beneficiary; and
8. other items not enumerated above may also represent fringe benefits.

Fringe benefits for the personal benefits of the provider-based physician are includable as part of his or her total compensation.

Items furnished to the employee for the convenience of the provider are not considered fringe benefits. This may include the provider's cost of meals and room and board, prerequisites (uniforms and laundry), operating day care centers for the children of employees, and provider-paid educational courses for the children of employees, and provider-paid educational courses advancing only the provider's interests. Although these costs are not classified as fringe benefits, they may be included in a provider's allowable cost to the extent they are reasonable in amount and related to patient care.

The reasonable cost of sick leave taken by an employee of a provider is recognized as a fringe benefit and included in allowable cost only when the provider makes payment for the sick leave. Payment in lieu of sick leave taken is not recognized by the program as payment for sick leave but is recognized as additional compensation. To be included in allowable costs, this payment in lieu of sick leave taken, along with other forms of compensation paid to an employee, must be reasonable. If the employee is an owner, the requirements of Chapter 9, PRM, Compensation of Owners, applies.

Where a provider maintains a coffee shop or restaurant in addition to a food service facility for its employees, a question arises as to whether the food service facility for employees is necessary. The answer, of course, depends on the circumstances. For example, the food service facility for employees, say, a cafeteria, may be open only for lunch while the coffee shop or restaurant is open for three meals. Under these conditions, it must be determined whether the employee's cafeteria is needed. If not, if the employees can be served in the coffee shop or restaurant, the unrecovered costs of the employee cafeteria are unallowable.

ALLOWABLE COSTS OF GOVERNMENTAL SUPPORT SERVICES TO STATE AND LOCAL GOVERNMENT PROVIDERS

Agencies and departments of State and local governments often furnish providers operated by such governments with facilities and services necessary to the operation of those providers. These facilities and services include such items as motor pool, legal counsel, purchasing, personnel administration, data processing, payroll maintenance and operation of plant, accounting, budgeting, auditing, and mail and messenger services.

The costs of such facilities and services are includable in the allowable costs of the provider to the extent they are:

1. reasonable;
2. related to patient care;
3. allowable under Medicare regulations; and
4. allocated on an acceptable basis.

Allowable services may also include an allocable share of supportive and supervisory time directly spent in furnishing the service to the provider. They should not include supervision of a general nature such as that of a department head or staff assistants not directly involved in specific operations.

Any grants, Federal or private, or gifts received by State and local governments for operating expenses must be offset against allowable costs.

The following expenses are unallowable:

1. general administrative costs of State and local governments -- such as the general expenses of State and local governments in carrying out the coordinating, fiscal and administrative functions of government, and public services such as fire, police and sanitation, tax administration and collection, and water;
2. chief executive officer's expenses -- the salaries and expenses of the office of the Governor of a State or the chief executive of a political subdivision;
3. legislative expenses -- salaries and other expenses of the State legislature or similar local governmental lawmaking bodies such as county supervisors, city council, etc.; and
4. tax anticipation warrants and property tax functions.

ADMINISTRATIVE COSTS INCURRED AFTER PROVIDER TERMINATES PARTICIPATION IN PROGRAM

When a provider terminates its participation in the program, either voluntarily or involuntarily, or a change of ownership occurs, administrative costs associated with the preparation and settlement of cost reports will be incurred after the effective date of termination. The direct administrative costs that are reasonable and related to the settlement of reimbursement for patient care rendered while the provider was participating in the program and bad debts resulting from co-pay and deductibles billed to Medicare patients are allowable.

Examples of allowable direct administrative costs are salaries and those costs associated with such salaries, i.e., fringe benefits, workers' compensation insurance, and payroll taxes; accounting and legal fees which are incurred for bill preparation, bill processing, and cost report preparation; and, where applicable, hearing fees and expenses incurred for settlement with an intermediary and other third parties.

However, legal fees and related costs incurred in the sale of the facilities, costs incurred on or after the effective date of termination for the operation or maintenance or closing of the facility are not allowable.

The allowable direct administrative costs, to the extent they are necessary, proper, and reasonable, are to be included in the provider's final cost report for the period ending with the date of termination of its participation in the program or change of ownership. These costs are subject to cost allocation and apportionment. The provider must maintain adequate records to enable the intermediary to identify and verify such costs that are included in the final cost report.

When a provider incurs additional allowable direct administrative costs after filing a final cost report, the provider should notify the intermediary. The intermediary may adjust the final cost report or require the provider to file an amended cost report, depending on the materiality of the adjustments. When a provider is required to file an amended cost report, such report is due within 45 days after the date of notification by the intermediary.

ALLOWANCE IN LIEU OF RECOGNITION OF OTHER COSTS

Merely as a bit of historical background, you should know that for a three year period at the beginning of the Medicare program, from July 1, 1966, to June 30, 1969, there was an allowable cost called allowance in lieu of recognition of other costs.

This allowance was partly in lieu of a direct interest return on the equity capital of providers and partly in recognition of the lack of precision in cost finding in the early stages of the Medicare program, as well as in lieu of other elements of cost not specifically recognized.

For non-profit providers, the allowance was two percent of the total cost exclusive of interest expense and the return allowed on equity capital. The allowance for proprietary providers was one and one-half percent.

The allowance in lieu of specific recognition of other costs was eliminated for cost-reporting periods beginning after June 30, 1969.

CHAPTER 6

COST LIMITATIONS

Limits on Routine Costs

Lower of Cost or Charges

Limitation on Therapy and Other
Services Furnished by Outside Suppliers

Limitation on Reimbursement for
Capital Expenditures

COST LIMITS

The 1972 Amendments to the Social Security Act made some important changes in the law, especially through imposing limitations on some costs.

The amendments established:

1. Limits on costs in excess of those necessary in the efficient delivery of needed health services;
2. Limits on payments for services to the lower of reasonable cost or customary charges;
3. Limits on reimbursement for capital expenditures which have not been approved by a State planning agency;
4. Limits on therapy and other services furnished by outside suppliers.

The following sections describe these cost limitations in more detail.

Limitation of Routine Costs

The original Medicare law expressed an intent to reimburse providers "the actual costs of providing high quality care, regardless of how widely the costs may vary from provider to provider, except where a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization and other relevant factors."

Experience under the program indicated that costs can also vary from one institution to another as a result of inefficient operations, or excessive services, or luxury accommodations supplied to patients. The 1972 Amendments recognized this possibility and authorized the Secretary to set limits on costs for certain classes of providers in various service areas.

There were certain restrictions on the new authority given to the Secretary.

1. The authority to impose limits was to be exercised on a prospective basis rather than on a retroactive basis. This gave providers advance notice of the limits to incurred costs and an opportunity to act to avoid incurring costs that were not reimbursable.
2. The evaluation of the costs necessary in delivering covered services to Medicare patients was to be exercised on a class and presumptive basis. "A class and presumptive basis" means that the cost limits were to be established on a group basis and the same limits applied to every provider in the group. If a provider within a group wants to file for an exception from the group limits, the burden of proof is on the provider to show why the limits should not be applied to it.
3. Since the limits would be defined in advance, the provider could charge the Medicare beneficiary for the cost of items or services

more expensive than those that are determined to be necessary in the efficient delivery of needed health services.

There were certain requirements and restrictions imposed on the provider before such charges could be made. The principal requirements were that the provider identify such charges to the Medicare patients as charges for excess costs, and that HCFA provide notice to the public of the charges the provider is authorized to impose on Medicare patients. (See Section 2570 of the Provider Reimbursement Manual for other requirements.)

In developing the cost limits, it was found that comparison of the costs of ancillary services was not immediately feasible. For this reason, cost limits initially were restricted to hospital inpatient general routine service costs even though the 1972 Amendments authorized cost limits for all costs and for all types of providers.

Hospital cost limits have been in effect since July 1, 1974. The schedule of hospital cost limits has been revised periodically to reflect changes in hospital costs and modifications of the hospital cost limits classification system. HCFA is continuing to work on improving the hospital cost limits classification system. Some major changes were made as of July 1, 1979, and July 1, 1980. These changes are discussed later in this section.

The hospital cost limits classification system was designed to group hospitals of similar size and economic environment. Analysis showed there was a relationship between bed size and routine cost as well as between bed size and range of services, with larger hospitals having more extensive services and higher costs. Cost report data indicated that hospitals in metropolitan areas incurred relatively higher costs than those in nonmetropolitan areas.

Metropolitan location was defined as being within the boundaries of a Standard Metropolitan Statistical Area (SMSA). The Office of Management and Budget has defined an SMSA as a standard national measure of an integrated economic and social unit having a large population center. Per capita income for different areas was uniformly available and was used as an indicator of conditions in the local economy. This is why per capita income, bed size and location were used in the classification system.

Initially, States were segregated into five groups according to per capita income. Hospitals in each State group were classified as either SMSA or non-SMSA and were further classified into seven bed sizes. Routine per diem costs of the hospitals in each of the resulting groups were arrayed in descending order. During the first year, the cost limit for each group was set at a per diem equal to the 90th percentile amount plus ten percent of the median.

Beginning July 1, 1975, the classification system was modified to recognize the similarity among hospitals within SMSAs which crossed State lines. Hospitals in each SMSA group were classified according to bed size.

The non-SMSA groups of the States were segregated into five State groups according to State non-SMSA per capita income. Hospitals in each non-SMSA group were classified according to bed size. Routine per diem costs in each of the resulting classifications were arrayed in descending order.

As a result of the modification, the classification system produced groups showing greater similarity. Therefore, the cost limits were reduced and set at a per diem equal to the 80th percentile plus ten percent of the median for each group.

The following schedules are examples of:

1. Per capita State groups;
2. Bed size categories;
3. Schedule of limits on Hospital Inpatient General Routine Service Costs.

1. PER CAPITA STATE GROUPS

The following is a list of States grouped on the basis of per capita income:

Alaska California Connecticut	<u>STATE GROUP I</u>	New Jersey New York Washington, D.C.
	Hawaii Illinois Nevada	
Delaware Maryland Massachusetts	<u>STATE GROUP II</u>	Rhode Island Washington
	Michigan Ohio Pennsylvania	
Arizona Colorado Florida Indiana Iowa	<u>STATE GROUP III</u>	New Hampshire Oregon Virginia Wisconsin
	Kansas Minnesota Missouri Nebraska	
Georgia Idaho Maine Montana	<u>STATE GROUP IV</u>	Utah Vermont Wyoming
	North Carolina Oklahoma South Dakota Texas	
Alabama Arkansas Kentucky Louisiana	<u>STATE GROUP V</u>	South Carolina Tennessee West Virginia
	Mississippi New Mexico North Dakota Puerto Rico	

2. Bed Size Categories — Hospitals are classified on the basis of the following seven bed size categories:

Less than 55	265-404
55-99	405-684
100-169	685 or More
170-264	

NOTE: In 1980, bed size categories for the labor-related components and the nonlabor related components were changed as follows:

TABLE I. - Hospitals Located in SMSA

Bed Size

Less than 100
100 to 404
405 to 684
685 and above

TABLE II. - Hospitals Located in Non-SMSA Areas

Bed Size

Less than 100
100 to 169
170 and above

(See explanation of labor-related components and nonlabor-related components in following pages.)

The following Schedule of Limits on Hospital Inpatient General Routine Service Costs is for cost reporting periods beginning on or after July 1, 1974. This schedule is the latest one in the Provider Reimbursement Manual (PRM).

Updates of the schedules of cost limits for subsequent years have been published annually in the Federal Register. The most current update was published in the Federal Register on Tuesday, April 1, 1980 (Vol. 45, No. 64).

3.

SCHEDULE OF LIMITS ON HOSPITAL INPATIENTGENERAL ROUTINE SERVICE COSTS

The following dollar limitations apply to the total of the hospital inpatient general routine service costs and the inpatient routine nursing salary cost differential (excluding costs incurred for special care units and ancillary services). These limits require adjustment as provided in Section 2520.1C (PRM). Such adjusted limits are applicable to cost reporting periods beginning on or after July 1, 1974, and before the earlier of July 1, 1975, or the effective date of any revised schedule.

Hospitals Located Within SMSA's (urban)

State	Bed Size						
	Less than 55	55 to 99	100 to 169	170 to 264	265 to 404	405 to 684	685 or more
Alabama	\$ 71	\$ 74	\$ 67	\$ 74	\$ 76	\$ 74	\$ 74
Alaska	143	135	138	139	128	150	167
Arizona	100	86	86	87	82	90	90
Arkansas	71	74	67	74	76	74	74
California	114	108	111	112	102	120	134
Colorado	100	86	86	87	82	90	90
Connecticut	114	108	111	112	102	120	134
Delaware	84	91	88	91	98	99	128
District of Columbia	114	108	111	112	102	120	134
Florida	100	86	86	87	82	90	90
Georgia	71	77	76	78	76	77	77
Hawaii	131	124	127	128	117	138	154
Idaho	71	77	76	78	76	77	77
Illinois	114	108	111	112	102	120	134
Indiana	100	86	86	87	82	90	90
Iowa	100	86	86	87	82	90	90
Kansas	100	86	86	87	82	90	90
Kentucky	71	74	67	74	76	74	74
Louisiana	71	74	67	74	76	74	74
Maine	71	77	76	78	76	77	77
Maryland	84	91	88	91	98	99	128
Massachusetts	84	91	88	91	98	99	128
Michigan	84	91	88	91	98	99	128
Minnesota	100	86	86	87	82	90	90
Mississippi	71	74	67	74	76	74	74
Missouri	100	86	86	87	82	90	90
Montana	71	77	76	78	76	77	77
Nebraska	100	86	86	87	82	90	90

3. (continued)

Hospitals Located Within SMSA's (urban)

State	Bed Size						
	Less than 55	55 to 99	100 to 169	170 to 264	265 to 404	405 to 684	685 or more
Nevada	\$114	\$108	\$111	\$112	\$102	\$120	\$134
New Hampshire	100	86	86	87	82	90	90
New Jersey	114	108	111	112	102	120	134
New Mexico	71	74	67	74	76	74	74
New York	114	108	111	112	102	120	134
North Carolina	71	77	76	78	76	77	77
North Dakota	71	74	67	74	76	74	74
Ohio	84	91	88	91	98	99	128
Oklahoma	71	77	76	78	76	77	77
Oregon	100	86	86	87	82	90	90
Pennsylvania	84	91	88	91	98	99	128
Puerto Rico	76	79	72	80	82	80	80
Rhode Island	84	91	88	91	98	99	128
South Carolina	71	74	67	74	76	74	74
South Dakota	71	77	76	78	76	77	77
Tennessee	71	74	67	74	76	74	74
Texas	71	77	76	78	76	77	77
Utah	71	77	76	76	76	77	77
Vermont *							
Virginia	100	86	86	87	82	90	90
Washington	84	91	88	91	98	99	128
West Virginia	71	74	67	74	76	74	74
Wisconsin	100	86	86	87	82	90	90
Wyoming *							

* No Standard Metropolitan Statistical Areas for these States.

3.

Hospitals Located Outside SMSA's (nonurban)

State	Bed Size						
	Less than 55	55 to 99	100 to 169	170 to 264	265 to 404	405 to 684	685 or more
Alabama	\$ 61	\$ 58	\$ 59	\$ 65	\$ 57	\$ 57	\$ 57
Alaska	132	116	125	107	102	102	102
Arizona	69	65	70	69	78	78	78
Arkansas	61	58	59	65	57	57	57
California	97	92	99	86	82	82	82
Colorado	69	65	70	69	78	78	78
Connecticut	97	92	99	86	82	82	82
Delaware	91	83	82	77	67	67	67
Florida	69	65	70	69	78	78	78
Georgia	68	65	71	66	83	83	83
Hawaii	121	107	115	98	94	94	94
Idaho	68	65	71	66	83	83	83
Illinois	97	92	99	86	82	82	82
Indiana	69	65	70	69	78	78	78
Iowa	69	65	70	69	78	78	78
Kansas	69	65	70	69	78	78	78
Kentucky	61	58	59	65	57	57	57
Louisiana	61	58	59	65	57	57	57
Maine	68	65	71	66	83	83	83
Maryland	91	83	82	77	67	67	67
Massachusetts	91	83	82	77	67	67	67
Michigan	91	83	82	77	67	67	67
Minnesota	69	65	70	69	78	78	78
Mississippi	61	58	59	65	57	57	57
Missouri	69	65	70	69	78	78	78
Montana	68	65	71	66	83	83	83
Nebraska	69	65	70	69	78	78	78
Nevada	97	92	99	86	82	82	82
New Hampshire	69	65	70	69	78	78	78
New Jersey	97	92	99	86	82	82	82
New Mexico	61	58	59	65	57	57	57
New York	97	92	99	86	82	82	82
North Carolina	68	65	71	66	83	83	83
North Dakota	61	58	59	65	57	57	57
Ohio	91	83	82	77	67	67	67
Oklahoma	68	65	71	66	83	83	83
Oregon	69	65	70	69	78	78	78
Pennsylvania	91	83	82	77	67	67	67
Puerto Rico	65	63	63	70	61	61	61
Rhode Island	91	83	82	77	67	67	67

3. (continued)

Hospitals Located Outside SMSA's (nonurban)

State	Bed Size						
	Less than 55	55 to 99	100 to 169	170 to 264	265 to 404	405 to 684	685 or more
South Carolina	\$ 61	\$ 58	\$ 59	\$ 65	\$ 57	\$ 57	\$ 57
South Dakota	68	65	71	66	83	83	83
Tennessee	61	58	59	65	57	57	57
Texas	68	65	71	66	83	83	83
Utah	68	65	71	66	83	83	83
Vermont	68	65	71	66	83	83	83
Virginia	69	65	70	69	78	78	78
Washington	91	83	82	77	67	67	67
West Virginia	61	58	59	65	57	57	57
Wisconsin	69	65	70	69	78	78	78
Wyoming	68	65	71	66	83	83	83

There were some major changes in the methodology for determining cost limits as of July 1, 1979.

1. Capital related costs, e.g., depreciation, rent, insurance, interest, have been excluded from the costs subject to cost limits.

Likewise, the cost of approved medical education programs, e.g., residents and interns, nursing schools, have been excluded from costs subject to cost limits.

2. Area per capita income, which was used to account for general economic environment, is no longer part of the classification system. Classification is based on whether a hospital is located within a Standard Metropolitan Statistical Area (SMSA) and on the hospital's bed size. (In New England, the New England County Metropolitan Areas (NECMA) are used to determine urban location.)
3. A wage index, developed from service industry wages, is used to adjust the wage portion of the limits to reflect differing wage levels among the areas in which hospitals are located.
4. A "market basket" index developed from the price of goods and services purchased by hospitals is used to account for the impact of changing wage and price levels on hospital costs. This index is used to adjust hospital cost data in the cost reporting periods to which the limits will apply.

Included in the "market basket" are wages and salaries, payroll fringe benefits and other fringe benefits, professional fees, malpractice insurance, food, fuel and other energy, rubber and miscellaneous plastics, business travel, apparel and textiles, business services and other miscellaneous expenses.

5. Previously, limits on inpatient general routine costs were set at the 80th percentile plus ten percent of the group median. The ten percent tolerance has been eliminated because improvements in the classification system make it unnecessary.

The current cost limits are based on, and applied to, inpatient general routine service costs plus an inpatient routine nursing salary cost differential. The inpatient general routine operating costs are the same as routine service costs from which are subtracted capital-related costs and costs of medical education. (See Chapter 9 in this manual for description of the inpatient routine nursing salary cost differential.)

Capital-related costs include interest, depreciation, insurance, rent, and fixed-asset related costs which are normally recorded in the depreciation accounts for Medicare reimbursement purposes.

Costs of medical education are the costs usually recorded in the Intern and Resident Account and in the Nursing Schools Account for Medicare reimbursement purposes.

There were some additional major changes in the methodology proposed as of July 1, 1980. (See Federal Register for Tuesday, April 1, 1980 (Vol. 45, No. 64) for details and additional explanation.)

1. Separate treatment of labor-related and nonlabor components of per diem costs was provided.
2. Limits set at 112 percent of the mean labor-related and mean non-labor costs of each comparison group were proposed as a reasonable margin factor.
3. The hospital wage index is to be applied to employee benefits, professional fees, costs of business services, and other miscellaneous expenses, as well as to wages.
4. It was proposed to increase each hospital's otherwise applicable cost limit for the costs generated by approved medical education programs.
5. The market basket index was adjusted in accordance with projected rates of increases in the prices for each category.
6. An adjustment was made to increase the otherwise applicable limits for hospitals in certain parts of the country that have shorter lengths of stay for their patients. The hospitals claim that the shorter lengths of stay result from higher intensity of routine services.

Hospitals may seek relief from the cost limits under certain circumstances. Hospitals can be reclassified if the criteria used in the classification system were wrongly applied resulting in an incorrect classification. The only basis for reclassification is the misapplication of the system. A dispute over the propriety of the system itself cannot serve as the reason for a provider's reclassification.

There are some exemptions from cost limits which may be granted in the following circumstances:

- (1) Sole community hospital. The hospital, by reason of factors such as isolated location or absence of other hospitals is the sole source of such care reasonably available to beneficiaries.
- (2) New Provider. The provider of inpatient services has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years. An exemption granted under this paragraph expires at the end of the provider's first cost reporting period beginning at least two years after the provider accepts its first patient.

- (3) Medical and Paramedical education. The provider can demonstrate that, when compared to other providers in its group, it incurs increased costs for items or services covered by limits under this section because of its operation of an approved education program.
- (4) More intensive routine care. The hospital:
- (i) Furnishes a greater intensity of inpatient general routine care than other hospitals having a reasonably similar mix of patients;
 - (ii) Shows that the more intensive care results in a shorter average length of stay and higher per unit costs than in comparable hospitals;
- (5) Essential community hospital services exception. The Secretary finds that:
- (i) The hospital exceeds its applicable limit by more than 15 percent;
 - (ii) Full application of the limits would render the hospital insolvent;
 - (iii) Such insolvency would deprive the community of essential services; and
 - (iv) The hospital has taken, or provided adequate assurances that it plans to take all available efficiency and economy measures to bring its costs into line with those of comparable facilities. In this case, the Secretary may grant an exception to the limit for the amount by which the hospital exceeds 115 percent of its applicable limit for such period as he deems necessary (but not to exceed the period during which the hospital meets the enumerated conditions).
- (6) Newly established home health agency. The agency can demonstrate that:
- (i) It has operated as the type of provider for which it was certified for Medicare under present and previous ownership for less than three full years. (An exception may not be granted under this paragraph for any cost reporting period beginning more than two years after the provider makes its first visit.);
 - (ii) Its variable operating costs were reasonable in relation to its utilization during the year, and
 - (iii) Its fixed operating costs are reasonable in relation to realistic projection of utilization to be achieved at the end of the provider's second year of operation.

- (7) Unusual labor costs. The provider has a percentage of labor costs which varies more than ten percent from that included in the promulgation of the limits.

In all cases of exception, exemption and reclassification, the hospital must demonstrate the need for the adjustment. In addition, the hospital must supply evidence that the conditions required for the adjustment are present and that excessive costs cannot be attributed to other causes.

HCFA has the responsibility for review of all Medicare requests for exception. The requests for exceptions must be submitted by the provider through its intermediary.

Any provider that applies for an exception to the cost limits must agree to an operational review at the discretion of HCFA. The findings from any such review may be the basis for recommendations for improvements in the efficiency and economy of the provider's operations. If such recommendations are made, any future exceptions shall be contingent on the provider's implementation of these recommendations.

Medicare has also recently developed cost limits for home health agencies (HHAs) and skilled nursing facilities (SNFs). Cost limits for home health agencies became effective on July 1, 1979, and for skilled nursing facilities on October 1, 1979. (See regulations for details.)

LOWER OF COST OR CHARGES

Sometimes a provider's customary charges to the general public are set at a level which does not reflect the provider's full cost. The charges are lower than costs because the provider has other income, e.g., endowment income or investment income or specific gifts, which it can use to meet the costs in excess of the charges.

Congress considered it inequitable for the Medicare program to pay higher amounts for services received by Medicare patients than the same patients would have been charged if they were not covered by the Medicare program. As a result, the 1972 Amendments limited reimbursement to providers to the lower of the reasonable cost of providing services or the customary charges to the general public for those services. This rule became effective for cost reporting periods beginning after December 31, 1973.

Customary charges are those uniform charges listed in a provider's established charge schedule which is in effect and applied consistently to most patients and recognized for program reimbursement.

Application of the provision of lower of cost or charges (LCC) requires that a comparison be made of the total reasonable cost and the total customary charges of the items or services furnished Medicare patients. All customary charges for items and services are added together without regard to whether the items or services are reimbursable under Part A or Part B or Medicare. Likewise, the reasonable costs of such items are added together and the two totals are compared. If the total customary charges are less than the total reasonable costs, payment to the provider is based on the total customary charges.

It was recognized that a provider's charges may be lower than costs in a given period because of a miscalculation or special circumstances of limited duration. Since there was not intent in the 1972 Amendments to penalize providers for short-term discrepancies, providers are permitted to carry forward their unreimbursed reasonable cost for reimbursement to the two succeeding cost reporting periods. Amounts carried forward may be reimbursed but only to the extent total customary charges exceed total reasonable cost in each subsequent period, subject, however, to cost limits based on the efficient delivery of needed health services.

For example, in 1978 a provider's total charges amounted to \$90,000 against reasonable costs of \$100,000, hence the intermediary disallowed \$10,000. The provider may carry the unreimbursed \$10,000 to 1979 and to 1980, but reimbursement is limited to the extent total customary charges exceed total reasonable cost in each year.

In 1979, assume the provider's total customary charges were \$110,000 against reasonable costs of \$106,000. The provider will be reimbursed \$4,000 (\$110,000 minus \$106,000) of the 1978 carryover and will have \$6,000 to carry over to 1980.

A new provider may carry forward its unreimbursed reasonable cost for the five succeeding cost reporting periods. A new provider is an institution that has operated in the program under present and previous ownership for less than three full years.

Exempted from the provision of lower of cost or charges (LCC) are public providers that render services either free or at a nominal charge. A public provider means any provider owned by a Federal, State, county, city or other local government agency or instrumentality. Nominal charges are defined as aggregate customary charges which are less than one-half of the reasonable cost of services or items represented by such charges.

LIMITATION ON THERAPY AND OTHER SERVICES FURNISHED BY OUTSIDE SUPPLIERS

The 1972 Amendments also set limits on the amounts that could be paid to outside suppliers for performing therapy services. These limitations were applicable to the cost of physical therapy, occupational therapy, speech therapy and other therapies. The limitations were also applicable to services of other health-related specialists performed by outside suppliers for a provider, a clinic, a rehabilitation agency or a public health agency.

Reimbursement was limited to amounts equivalent to:

1. The salary and other costs that would have been incurred by the provider if the services had been performed by an employee-therapist; plus
2. An allowance to compensate for other costs an individual not working as an employee might incur in furnishing services under arrangements, for example, traveling expense, office expense, etc.

In no case may reasonable cost exceed the actual amount paid the outside supplier for services rendered.

The principle is applicable to both Part A and Part B services reimbursed on a reasonable cost basis.

The cost of therapy services furnished by outside suppliers is compared with the prevailing hourly salary rates paid to full-time employee-therapists in the geographical area. The prevailing salary is the hourly salary rate based on the 75th percentile of the range of salaries by type of therapy. These rates are based on salary data compiled by the Bureau of Labor Statistics in their triennial surveys. The rates are updated for intervening years through a wage index.

The allowance to compensate outside suppliers for other costs include both fringe benefits and expenses of a nonemployee therapist. The fringe benefits take into consideration vacation and sick pay, holidays, personal leave, insurance premiums, pension payments, job training, meals, severance pay, bonuses, etc.

The expenses considered include office space, telephone, bookkeeping, secretarial service, professional costs and appropriate insurance costs, such as liability and automobile insurance.

A standard fringe benefit and expense factor is used to take both fringe benefits and nonemployee expenses into account. The standard fringe benefit and expense factor has been calculated to be 50 percent of the prevailing hourly salary rate.

A standard travel allowance has also been established. The standard travel allowance is equal to one-half of the sum of the applicable prevailing hourly salary rate plus the fringe benefit and expense factor.

HCFA publishes guidelines periodically, showing the amounts of the prevailing hourly salary, the fringe benefit and expense factor and the standard travel allowance of the specific therapy in a specific geographical area.

(A copy of a Schedule of Guidelines for Physical Therapy Services Furnished by Outside Suppliers follows.)

The limitations on physical therapy furnished by outside suppliers became effective for cost reporting periods beginning on or after April 1, 1975.

Until December 1, 1978, therapy limitations were implemented only for physical therapy. After December 1, 1978, guidelines became effective for respiratory therapy as well. Guidelines are being developed for other therapy services.

EXHIBIT A-4

SCHEDULE OF GUIDELINES FOR PHYSICAL THERAPY
SERVICES FURNISHED BY OUTSIDE SUPPLIERS

Adjusted Hourly Salary Equivalency Amounts
and Standard Travel Allowances for
Qualified Physical Therapists
(Full Time, Regular Part Time, or Home Visits)

(This schedule is effective for services furnished on or after December 1, 1978. It is not to be used for physical therapy assistants or aides.)

<u>State</u>	<u>Adjusted Hourly Salary Equivalency Amount</u>	<u>Standard Travel Allowance</u>
Alabama	\$11.70	\$5.85
Alaska ¹	17.00	8.50
Arizona	13.70	6.85
Arkansas	11.30	5.65
California	13.70	6.85
Colorado	11.40	5.70
Connecticut	11.60	5.80
Delaware	13.70	6.85
District of Columbia	12.50	6.25
Florida	12.50	6.25
Georgia	11.00	5.50
Hawaii ²	16.10	8.05
Idaho	12.50	6.25
Illinois	12.50	6.25
Indiana	12.80	6.40
Iowa	11.40	5.70
Kansas	11.40	5.70
Kentucky	12.00	6.00
Louisiana	11.30	5.65
Maine	11.60	5.80

¹ Adjusted for 25 percent salary differential.

² Adjusted for 17.5 percent salary differential.

EXHIBIT A-4 (CONT.)

<u>State</u>	<u>Adjusted Hourly Salary Equivalency Amount</u>	<u>Standard Travel Allowance</u>
	\$12.00	\$6.00
Maryland	11.60	5.80
Massachusetts	13.50	6.75
Michigan	12.20	6.10
Minnesota	11.70	5.85
Mississippi	11.10	5.55
Missouri	11.40	5.70
Montana	11.40	5.70
Nebraska	13.70	6.85
Nevada	11.60	5.80
New Hampshire	13.70	6.85
New Jersey	11.30	5.65
New Mexico	14.10	7.05
New York	12.00	6.00
North Carolina	11.40	5.70
North Dakota	12.60	6.30
Ohio	11.30	5.65
Oklahoma	13.20	6.60
Oregon	12.80	6.40
Pennsylvania	11.60	5.80
Rhode Island	11.70	5.85
South Carolina	11.40	5.70
South Dakota	11.60	5.80
Tennessee	11.30	5.65
Texas	11.40	5.70
Utah	11.60	5.80
Vermont	12.00	6.00
Virginia	11.60	5.80
Washington	12.00	6.00
West Virginia	12.30	6.15
Wisconsin	11.40	5.70
Wyoming		

SCHEDULE OF GUIDELINES FOR RESPIRATORY THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERSAdjusted Hourly Salary Equivalency Amounts and Standard Travel Allowances for Registered and Certified Therapists
(Full Time or Regular Part Time)

(This schedule is effective for services furnished on or after December 1, 1978. It is not to be used for respiratory therapy aides or trainees.)

STATE	REGISTERED THERAPISTS		CERTIFIED THERAPISTS	
	Adjusted Hourly Salary Equivalency Amount	Standard Travel Allowance	Adjusted Hourly Salary Equivalency Amount	Standard Travel Allowance
Alabama	\$11.30	\$5.65	\$ 9.20	\$4.60
Alaska ¹	14.70	7.35	13.50	6.75
Arizona	11.70	5.85	10.80	5.40
Arkansas	11.10	5.55	8.10	4.05
California	11.70	5.85	10.80	5.40
Colorado	10.70	5.35	9.80	4.90
Connecticut	12.00	6.00	10.20	5.10
Delaware	12.90	6.45	11.00	5.50
D.C.	11.70	5.85	11.30	5.65
Florida	11.30	5.65	9.50	4.75
Georgia	11.30	5.65	8.70	4.35
Hawaii ²	13.80	6.90	12.80	6.40
Idaho	10.70	5.35	9.20	4.60
Illinois	11.60	5.80	10.40	5.20
Indiana	10.80	5.40	10.20	5.10
Iowa	10.40	5.20	8.90	4.45
Kansas	10.40	5.20	8.90	4.45
Kentucky	10.50	5.25	10.10	5.05
Maine	12.00	6.00	10.20	5.10

¹ Adjusted for 25 percent salary differential

² Adjusted for 17.5 percent salary differential

STATE	REGISTERED THERAPISTS		CERTIFIED THERAPISTS	
	Adjusted Hourly Salary Equivalency Amount	Standard Travel Allowance	Adjusted Hourly Salary Equivalency Amount	Standard Travel Allowance
Maryland	\$10.70	\$5.35	\$10.70	\$5.35
Massachusetts	12.00	6.00	10.20	5.10
Michigan	10.80	5.40	10.80	5.40
Minnesota	9.90	4.95	8.90	4.45
Mississippi	11.30	5.65	9.20	4.60
Missouri	10.70	5.35	8.90	4.45
Montana	10.70	5.35	9.80	4.90
Nebraska	10.40	5.20	8.90	4.45
Nevada	11.70	5.85	10.80	5.40
New Hampshire	12.00	6.00	10.20	5.10
New Jersey	12.90	6.45	11.00	5.50
New Mexico	11.10	5.55	8.10	4.05
New York	14.70	7.35	11.40	5.70
North Carolina	10.50	5.25	10.10	5.05
North Dakota	10.70	5.35	9.80	4.90
Ohio	10.40	5.20	9.90	4.95
Oklahoma	11.10	5.55	10.40	5.20
Oregon	10.10	5.05	10.20	5.10
Pennsylvania	11.10	5.55	10.40	5.20
Rhode Island	12.00	6.00	10.20	5.10
South Carolina	11.30	5.65	9.20	4.60
South Dakota	10.70	5.35	8.40	4.20
Tennessee	9.30	4.65	8.40	4.20
Texas	11.10	5.55	8.10	4.05
Utah	10.70	5.35	9.80	4.90
Vermont	12.00	6.00	10.20	5.10
Virginia	12.00	6.00	10.10	5.05
Washington	11.30	5.65	9.20	4.60
West Virginia	10.50	5.25	10.10	5.05
Wisconsin	10.80	5.40	9.60	4.80
Wyoming	10.70	5.35	9.80	4.90

LIMITATION ON REIMBURSEMENT FOR CAPITAL EXPENDITURES

The 1972 Amendments (Section 1122) authorized the Secretary to exclude from Medicare reimbursement to providers, amounts for depreciation, interest, return on equity capital, and other costs related to proposed or actual expenditures for plant and equipment which:

1. exceed \$100,000, or
2. change the bed capacity of the facility, or
3. substantially change the services provided by the facility, if the proposed or actual expenditures for plant and equipment have not been approved by the State planning agency or have been determined to be inconsistent with State or local health facility planning requirements.

In other words, providers were required to get approval from their local planning agencies before beginning any new construction or purchasing new equipment. The purpose of this amendment was to eliminate any unnecessary duplication of services and to avoid having more beds than were needed in the area.

To implement Section 1122 of the social Security Act, the Secretary has entered into agreements with States under the terms of which designated planning agencies in the States make findings and recommendations as to whether proposed or actual provider capital expenditures are consistent with the State and local health planning requirements of the area serviced by these agencies. The Public Health Service is the component within HHS responsible for issuing rules and regulations under which designated planning agencies review capital expenditures, render the decisions regarding such expenditures and hear any appeals of such decisions.

Some States have not entered into agreements with the Secretary. In such States, Section 1122 does not apply.

(See Section 2422ff in the PRM and see Federal Regulations, Part 100, Subpart A, Sections 100.101 to 100.110.)

These provisions also applied to costs in connection with capital assets which were donated or transferred to a provider and to the reasonable equivalent of any rental expense incurred by a provider pursuant to a lease or comparable arrangement. The test was whether the amount would have been excluded if the provider had acquired such a facility or equipment by purchase.

The provisions were effective for capital expenditures incurred after December 31, 1972, or the effective date of the agreement between the State and the Secretary, whichever is later.

A provider who is not satisfied with a disallowance of reimbursement for a capital expenditure may request reconsideration of the determination up to six months after notification. The request for reconsideration must be filed in accordance with the regulations issued by the Public Health Service (PHS). (See regulations, CFR Part 100, Subpart A, Sections 100.101 to 100.110).

If the provider disputes the dollar amount of the disallowance, the provider may use the regular Medicare appeals procedure, the same as for any other disputed Medicare reimbursement adjustment. (See PRM, Section 2426ff).

CHAPTER 7

ORGANIZATION AND OTHER CORPORATE COSTS

Stockholders Servicing Costs

Start-Up Costs

Planning Costs

ORGANIZATION AND OTHER CORPORATE COSTS

Organization costs are those costs directly incident to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organization costs extend over more than one accounting period and thus affect the costs of future periods of operation.

Allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and by-laws, legal agreements, minutes of organizational meeting, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meeting of directors and stockholders, and fees paid to States for incorporation.

The following types of costs are not considered allowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters' fees and commissions, accountant's or lawyer's fees, cost of qualifying the issues with the appropriate State or Federal authorities, stamp taxes, etc.

Unless specified otherwise herein, the provisions of this section are effective for providers after June 30, 1976.

Providers entering the program after June 30, 1976 should capitalize allowable organization costs. Allowable organization costs are amortized proportionally over a period of 60 months starting with the month the first patient is admitted for treatment. However, if in the opinion of the intermediary, these costs are not material when compared to total allowable costs, they may be included in allowable costs for the initial cost reporting period.

If the provider enters the program after 60 months starting with the month the first patient was admitted for treatment, no organization costs are recognized.

Organization costs can be capitalized retroactively but the organization costs must be reduced for any periods already elapsed from the time the first patient was admitted for treatment. This rule is applicable where a provider:

- (1) did not initially capitalize organization costs (or has written off such costs in the periods incurred) before entering the program;
- (2) can establish these costs to the satisfaction of the intermediary; and
- (3) enters the program within 60 months after the first patient was admitted for treatment.

Where the provider admitted its first patient for treatment within a 60 month period prior to entry into the program and has capitalized organization costs using a 60-month amortization period, no change in the rate of amortization is permitted. In this instance, the unamortized portion of organization costs is allowable under the program and is amortized over the remaining part of the 60-month period.

AMORTIZATION PERIOD LESS THAN 60 MONTHS

Where a provider has entered the program within 60 months after the first patient is admitted for treatment and has capitalized organization costs but has used an amortization period of less than 60 months, an adjustment will be necessary in order to include amortized organization costs in the provider's allowable costs. The unamortized amount of organization costs must be recomputed using a 60-month period starting with the month the first patient is admitted for treatment. The recomputed unamortized amount of organization costs, as of the month the provider enters the program, is recognized as an asset under the program and may be amortized over the remaining months of the 60-month period.

EXAMPLE: A provider enters the program 24 months after the first patient is admitted for treatment; organization costs were capitalized in the amount of \$12,000; amortization is based on a 36-month period.

	<u>Per Books</u>	<u>Medicare</u>
Organization costs to be amortized	\$ 12,000	\$ 12,000
Amount amortized to date		
$(24 \times \$12,000)$ <u>36</u>	8,000	
Book balance unamortized as of date of entry into program	\$ <u>4,000</u>	
Amount which would have been amortized on a 60-month basis		
$(24 \times \$12,000)$ <u>60</u>		\$ <u>4,800</u>
Total amount to be amortized under the program		\$ <u>7,200</u>

AMORTIZATION PERIOD LONGER THAN 60 MONTHS

Where a provider has entered the program within 60 months after the month the first patient is admitted for treatment and has capitalized organization costs, but used an amortization period longer than 60 months, an adjustment will be necessary if the provider chooses to include amortized organization costs in its allowable costs. The unamortized amount of organization costs must be recomputed as of the date of entry into the program using a 60-month period starting with the month the first patient was admitted for treatment. The unamortized amount so computed will be recognized for program purposes and may be amortized over the remaining part of the 60-month period.

EXAMPLE: A provider enters the program 36 months after the first patient is admitted for treatment; organization costs were capitalized in the amount of \$10,000; amortization is based on a 120-month period.

	<u>Per Books</u>	<u>Medicare</u>
Organization costs to be amortized	\$ 10,000	\$ 10,000
Amount amortized to date		
$\frac{(36 \times \$10,000)}{120}$	<u>3,000</u>	
Book balance unamortized as of date of entry into program	\$ <u>7,000</u>	
Amount which would have been amortized on a 60-month basis		
$\frac{(36 \times \$10,000)}{60}$		<u>6,000</u>
Total amount to be amortized under the program		\$ <u>4,000</u>

Sale of Institution

Where a provider institution is sold before the expiration of the amortization period, the portion of organization costs amortizable through the month of sale is includable in allowable costs.

If the unamortized balance of organization costs at the time of sale represents a value reflected in the selling price to the purchaser and contained in the sales agreement, this value will be limited to the lesser of the sales price attributed to the organization costs or the unamortized balance of organization costs on the books of the seller.

If the purchaser becomes a provider, the unamortized organization costs subject to the above limitation (reduced for any period in which the purchaser operates the facility before becoming a provider) may be amortized and included in allowable costs over the remaining portion of the 60-month period established for amortization by the seller-provider.

If the unamortized balance of organization costs at the time of sale is not identified in the sales price (the sales agreement does not allocate a portion of the sales price to the unamortized balance), the seller-provider may include the unamortized costs in its allowable costs for the last cost report submitted to the program.

Withdrawal from Program

Where a provider withdraws from the program, the portion of organization costs amortizable through the month of withdrawal is includable in allowable costs. The unamortized balance of organization costs is not allowable under the Medicare program but is considered applicable to services provided after the month of withdrawal.

However, where the provider ceases to provide health care services on withdrawal from the program, the unamortized costs at termination may be included in the provider's allowable costs for the last cost report submitted to the program.

Costs connected with the transfer of assets to a corporation must be capitalized as part of the cost of the asset.

The acquisition of capital stock of a provider does not constitute a transfer of assets to a corporation and, therefore, costs associated with such a transaction are not allowable.

Stockholder Servicing Costs

The following types of costs relevant to the proprietary and equity interests of the stockholders, but not related to patient care, are excluded from allowable costs. Costs incurred primarily for the benefit of stockholders or other investors, including, but not limited to:

- (1) the costs of stockholders' annual reports and newsletters,
- (2) annual meetings,
- (3) mailing of proxies,
- (4) stock transfer agent fees,
- (5) stock exchange registration fees,
- (6) stockbroker and investment analysis, and
- (7) accounting and legal fees for consolidating statements for SEC purposes.

Reorganization Costs

Costs connected with the reorganization of a corporation are not allowable costs, primarily because they are related to stock ownership changes and the indebtedness pertaining thereto. None of these costs is related directly or indirectly to patient care.

Start-up Costs

Start-up costs refers to the costs a provider incurs prior to the time the

first patient is admitted for treatment. Because these start-up costs are related to patient care services which will not be rendered until the institution is opened, they must be capitalized as deferred charges and amortized over a number of benefiting periods.

Start-up costs include, for example, administrative and nursing salaries, heat, gas, and electricity, taxes, insurance, mortgage and other interest, employee training costs, repairs and maintenance, housekeeping, and other allowable costs incident to the start-up period.

Amortized start-up costs are usually charged only to the "Administrative and General" cost center unless these costs can be specifically identified with a cost center or component of a provider, in which case the amortized costs must be directly assigned to the applicable cost center or component.

Unless otherwise specified herein, the provisions of this section are effective for providers after June 30, 1976.

Start-up costs are incurred from the time preparation begins on a newly constructed or purchased building, wing, floor, unit, or expansion thereof to the time the first patient, whether Medicare or non-Medicare, is admitted for treatment. Where the start-up costs apply to nonrevenue producing patient care functions, e.g., a storage area, the start-up period ends when the areas are used for their intended purposes.

If the intermediary determines that the start-up costs incurred immediately before a provider enters the program are immaterial, the start-up costs need not be capitalized, but rather, may be charged to operations in the first cost reporting period. The same rule applies where the provider incurs immaterial start-up costs while it is already in the program; these costs need not be capitalized but may be charged to operations in the periods incurred.

For program reimbursement purposes, costs of the provider's facility and building equipment should be depreciated over the lives of these assets starting with the month the first patient is admitted for treatment.

Where portions of the provider's facility are prepared for patient care services after the initial start-up period, these asset costs applicable to each portion should be depreciated over the remaining lives of the applicable assets.

Costs of major movable equipment should be depreciated over the useful life of each item starting with the month the item is placed into operation.

Where a provider prepares all portions of its facility for patient care services at the same time and has capitalized start-up costs, the start-up costs must be amortized proportionally over a period of 60 consecutive months beginning with the month in which the first patient is admitted for treatment.

Where a provider prepares portions of its facility for patient care services on a piecemeal basis, start-up costs must be capitalized and amortized separately for the portions of the provider's facility that are prepared for patient care services during different periods of time.

EXAMPLE:

Facts: On July 1, 1976, the provider entered the program with a new three-floor facility. The first two floors of the facility were prepared and available for patient care services at the time the provider entered the program; however, preparation of the third floor for patient care services was deferred until July 1, 1977. The first patient was admitted to the first two floors on July 5, 1976, while the first patient was admitted to the third floor on October 15, 1977. Start-up costs of \$60,000 were capitalized for the first two floors from the time preparation began on these floors for the rendition of patient care services to July 5, 1976. Start-up costs of \$25,000 were also capitalized for the third floor from July 1, 1977, to October 15, 1977.

With the above facts, the provider would accumulate the start-up costs of \$60,000 attributable to the first two floors separately from the start-up costs of \$25,000 attributable to the third floor.

The start-up costs of \$60,000 would be amortized at the rate of \$1,000 per month (for 60 months) beginning in July 1976 and ending June 1981.

The start-up costs of \$25,000 attributable to the third floor would be amortized at the rate of \$417 per month (for 60 months) from October 1977 to September 1982.

Where a provider enters the program more than 60 months after its first patient is admitted for treatment, the unamortized start-up costs at the time the provider enters the program will not be allowable.

Where a provider enters the program within 60 months after its first patient is admitted for treatment, the unamortized portion of the start-up costs at the time the provider enters the program may be included in allowable costs. The provider must use a 60-month amortization period starting with the month the provider admitted its first patient for treatment.

The costs must be recomputed as follows:

Example 1:

Facts: A provider enters the program on July 1, 1976, 30 months after it admitted its first patient; start-up costs were capitalized in the amount of \$30,000; and amortization is based on a 120-month period.

	<u>Per Books</u>	<u>Medicare</u>
Original amount of start-up costs to be amortized	\$ 30,000	\$ 30,000
Amount amortized as of July 1, 1976		
$\frac{(30 \times \$30,000)}{120}$	<u>7,500</u>	
Unamortized start-up costs as of July 1, 1976	<u>22,500</u>	
Amount which would have been amortized over 60 months		
$\frac{(30 \times \$30,000)}{60}$		<u>15,000</u>
Amount to be amortized under the program over a 30-month period		<u>\$15,000</u>

Example 2:

Facts: A provider enters the program on July 1, 1976, 24 months after it admitted its first patient; start-up costs were capitalized in the amount of \$36,000; and amortization is based on a 36-month period.

(continued on next page)

Example 2 - cont.

	<u>Per Books</u>	<u>Medicare</u>
Original amount of start-up costs to be amortized	\$ 36,000	\$ 36,000
Amount amortized as of July 1, 1976		
($\frac{24}{36} \times \$36,000$)	<u>24,000</u>	
Unamortized start-up costs as of July 1, 1976	\$ <u>12,000</u>	
Amount which would have been amortized over 60 months		
($\frac{24}{60} \times \$36,000$)		\$ <u>14,400</u>
Amount to be amortized under the program over a 36-month period		\$ <u><u>21,600</u></u>

Where a provider institution is sold before the expiration of the amortization period, the portion of start-up costs amortizable through the month of sale is includable in allowable costs.

If the unamortized balance of start-up costs at the time of sale represents a value reflected in the selling price to the purchaser and contained in the sales agreement, this value will be limited to the lesser of the sales price attributable to the start-up costs or the unamortized balance of start-up costs on the books of the seller.

If the purchaser becomes a provider, the unamortized start-up costs subject to the above limitation (reduced for any period in which the purchaser operates the facility before becoming a provider) may be amortized and included in allowable costs over the remaining portion of the period established for amortization by the seller-provider. An exception to this rule is granted if the delay in certification was caused by the program.

If the unamortized balance of the start-up costs at the time of sale is not identified in the sales price (i.e., the sales agreement does not allocate a portion of the sales price to this unamortized balance), the seller-provider may include the unamortized costs in its allowable costs for the last cost report submitted to the program.

Where a provider withdraws from the program, start-up costs amortizable through the month of withdrawal are includable in the allowable costs. Unamortized start-up costs after the month of withdrawal are applicable to future services and, therefore, are not includable in allowable costs.

However, where the provider ceases to provide health care services on withdrawal from the program, the unamortized costs at termination may be included in the provider's allowable costs for the last cost report submitted to the program.

PLANNING COSTS (ABANDONMENT OF PLANS)

When a provider plans for any physical plant construction or plans to purchase an existing facility or land to expand, rebuild, or relocate its present facility, it generally incurs planning costs. The planning costs may include feasibility studies, engineering studies, architect fees, finder's fees, etc., and usually involve the provider's staff and/or the use of outside consultants.

Planning costs generally become part of the historical cost of a completed facility. However, where a provider abandons its plans, the abandoned planning costs are allowable where the provider had planned to expand its present facility by adding new wings, departments, or buildings, which would have been included under its present certification, and such costs were reasonable.

On the other hand, where a provider plans to open a new facility which would be separately certified under the program, and the provider intends to continue to perform services at the present location, it would not be expanding its facility, but would be investing in a capital asset which would not be related to patient care until the facility was certified. Consequently, the costs of any abandoned plans would not be allowable under the program. This policy is effective for all cost reporting periods beginning on or after June 1, 1976.

DEFINITIONS

1. Expand -- To increase the size of a provider's facility. This includes the purchase or construction of wings, departments, and/or buildings that will be included in a provider's existing certification.
2. Rebuild -- To make extensive improvements; to restore to a previous state; to make extensive changes or to remodel; to tear down an existing provider's facility and build a new facility in the immediate proximity of the old facility.
3. Relocate -- To move an existing provider to a new location and close the old provider.

PLANNING COSTS WHERE FACILITY IS COMPLETED

These costs are recognized under Medicare when:

1. they are reasonable and prudent,
2. they become part of the historical cost of the completed facility,
3. the facility is certified to participate in the Medicare program, and

4. the facility has been approved under Section 1122 of the Social Security Act, if applicable. (See Section 2422ff.PRM.)

Any planning costs incurred to purchase land become part of the historical cost of the land and are not included in the historical cost of the depreciable assets of the completed facility. If a provider incurs planning costs for both land and a facility, and such costs cannot be specifically identified with either the land or facility, the provider must allocate the planning costs between the land and the facility based on the cost of each to the total cost.

PLANNING COSTS WHERE PLANS ARE ABANDONED

1. Allowable -- If a provider abandons its plans to construct or purchase a facility, the cost of such plans is allowable if the planning was for the purpose of expanding, rebuilding, or relocating the operations of the certified facility. Providers have the option of including the cost of the abandoned plans in allowable cost either in the year of abandonment or by amortizing them over a three-year period. If a provider received a restricted gift, grant, etc., for construction or purchase of a facility, both the principal and income from each gift, grant, etc., must be offset against the allowable costs of abandoned plans.
2. Nonallowable -- Costs of abandoned plans are not allowed when:
 - A. A provider plans to continue to operate its present facility and plans to construct or purchase a new facility which will be separately certified under the program. For example, if a participating hospital plans to construct or purchase a skilled nursing facility and abandons such plans, such costs are not allowable; or
 - B. Such costs are for the purchase of land to be used either for facilities or parking lots.

ABANDONMENT OF CONSTRUCTION-IN-PROGRESS

Where a provider begins construction of a new facility to expand, rebuild, or relocate its present certified facility and then later abandons the partially completed asset, the cost of this abandoned asset, excluding planning costs, is an investment loss and is not allowable under the Medicare program. If a provider abandons a partially constructed asset which would have become a newly certified facility, the loss, including abandoned planning costs, is not allowable.

CHAPTER 8

PURCHASE DISCOUNTS, ALLOWANCES,

REFUNDS OF EXPENSES

PURCHASE DISCOUNTS, ALLOWANCES, REFUNDS OF EXPENSES

Purchase discounts, allowances, refunds and rebates given to the provider are used to reduce the specific costs to which they apply in the accounting period in which the purchase occurs. The discounts, allowances, refunds and rebates are not to be considered a form of income by the provider.

Providers are expected and encouraged to take advantage of available discounts. If a provider's costs are inflated from failure to take advantage of available discounts, when the provider is able to do so, then the intermediary may disallow the excess costs.

Purchase discounts within the meaning of this principle include cash, trade and quantity discounts.

Cash discounts are reductions granted for the settlement of debts within a stipulated period before they become due. Thus, the terms "2/10, net 30" on a vendor invoice mean that a 2 percent discount from the purchase price will be allowed if payment is made within ten days from the date of the invoice.

Example: An invoice for supplies indicates a price of \$500 with terms 2/10, net 30. The provider paying the invoice within ten days would remit \$490 in satisfaction of the invoice and this would be the actual cost to the provider.

Purchase Price	\$ 500.00
Less: Cash Discount (2% of \$500)	<u>10.00</u>
Net Payment	\$ <u>490.00</u>

Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms.

Example: The invoice for a quantity of supplies purchased indicates a total list price of \$2,400 with trade discounts of 30 percent and 10 percent, and cash discount terms of 2/10, net 30.

List Price	\$ 2,400.00
Less 30% (of \$2,400)	<u>720.00</u>
	\$ 1,680.00
Less 10% (of \$1,680)	<u>168.00</u>
	\$ 1,512.00
Less 2% (of \$1,512)	<u>30.24</u>
Cash Discount	
Amount Payable	\$ <u>1,481.76</u>

Quantity discounts are reductions from list prices granted because of the size of individual or total purchases.

Example: Paper products are purchased from a supplier during the year and the supplier agrees to grant a 5 percent discount when the provider's quantity purchases of this type product total at least \$1,500. In addition, the supplier allows cash discount terms of 2/10, net 30.

If the provider purchases paper products totalling \$1,700, his payment would be computed as follows:

Purchases	\$ 1,700.00
Less 5% of \$1,700	<u>85.00</u>
	\$ 1,615.00
Less 2% of \$1,615 (Cash Discount)	<u>32.30</u>
Net Cost	\$ <u><u>1,582.70</u></u>

Allowances are deductions granted or accepted by the creditor for damage, delay, shortage, imperfection or other cause, excluding discounts and refunds.

Example: A provider purchases a quantity of dishes costing \$1,200 which is received in a damaged condition. In consideration of the provider's acceptance of the damaged shipment, the supplier grants a \$200 allowance to the provider. The supplier also allows cash discount terms of 2/10, net 30.

Purchases	\$ 1,200.00
Less: Allowance	<u>200.00</u>
	\$ 1,000.00
Less: 2% of \$1,000 (Cash Discount)	<u>20.00</u>
Net Cost	\$ <u><u>980.00</u></u>

Refunds are amounts paid back by the vendor generally in recognition of damaged shipments, overpayments, or returned purchases.

Refunds of container deposits are not purchase refunds under this definition.

Rebates represent refunds of a part of the cost of goods or services. A rebate is commonly based on the total amount purchased from a supplier and differs from a quantity discount in that it is based on the value of purchases, whereas quantity discounts are generally based on the quantity purchased.

Where the purchase occurs in one accounting period and the related allowance or refund is not received until the subsequent period, an accrual in the initial period should be made of the amount if it is significant, and cost correspondingly reduced. However, if this cannot be readily accomplished, such amounts may be used to reduce comparable expenses in the period in which they are received.

(An accrual means keeping the records so that the expenses incurred and the income earned in a given period are included in that period even though such expenses may not have actually been paid or income received in cash in that period.)

Rebates in the form of cash payments based on the total value of purchases in one accounting period are not generally received until the subsequent accounting period. Where the amount of the rebate can be determined, it should be accrued in the initial period and costs for that period correspondingly reduced. A reasonable effort should be made to accrue accurate amounts for allowances and rebates which will be received after the books have been closed. The difference between the accrual and the actual amount received may then be entered in the period in which it is actually received.

Where a discount, allowance, refund, or rebate is received on supplies or services, the cost of which is apportioned under the Medicare program, it must be used to reduce the total cost of the goods or services for all patients without regard to whether or not the discount, allowance, refund or rebate is designated for supplies or services used by all patients or by a specific group or category of patients (e.g., Medicare or non-Medicare patients only).

Payments to a provider by its vendor or supplier will be considered as discounts, refunds, or rebates in determining allowable costs under the program even though these payments may be treated as "contributions" or "unrestricted grants" by the provider and the vendor.

However, sometimes such payments may represent a true donation or grant, for example, when:

1. They are made by a vendor in response to building or other fund raising campaigns in which community-wide contributions are solicited; or
2. They are in addition to discounts, refunds, or rebates which have been customarily allowed under arrangements between the provider and the vendor; or
3. The volume or value of purchases is so nominal that no relationship to the contribution can be inferred; or
4. The contributor is not engaged in business with the provider or a facility related to the provider.

Where any of these conditions are met, the payments will be subject to the rules relating to grants, gifts, and income from endowments.

Where an owner or other official of a provider directly receives from a vendor monetary payments or goods or services for his own personal use as a result of the provider's purchases from the vendor, the value of such payments, goods, or services constitutes a type of refund or rebate and should be applied as a reduction of the provider's costs for goods or services purchased from the vendor.

Where the purchasing function for a provider is performed by a central unit or organization, all discounts, allowances, refunds and rebates should be used to reduce the costs of the provider in accordance with the instructions above. These should not be treated as income of the central purchasing function or used to reduce the administrative costs of that function.

Amounts paid by a supplier for the use of space or equipment in a hospital or skilled nursing facility will usually be found to constitute a form of discount, whether paid as a percentage of charges or as a flat amount per bed or per time period.

Example: A supplying pharmacy "leases" a room in a skilled nursing facility in which to store drugs used by inpatients of the institution. Charges by the pharmacy to the SNF for drugs are \$10,000 and, at the same time, \$2,000 is paid back to the provider as rent. The cost incurred by the provider for this space (i.e., depreciation, maintenance, etc.) is \$500. Allowable drug costs would be $\$10,000 + \$500 - \$2,000 = \$8,500$.

Payments made by a supplier to a provider in recognition of the fact that the supplier is relieved of the need to collect individual bills from the patients of the provider — sometimes called "accounting fees" or "collection fees" — are considered a form of discount, refund, or rebate and should be used to reduce the costs of the goods or services purchased from the supplier.

Monetary damages received by a provider as a result of a court decision, settlement, legal action, or other claim for damages, are considered reductions of cost if they represent recoveries of previously allowed costs.

Punitive damages, i.e., those damages specifically designated punitive damages by the court, are not treated as reductions of costs.

Amounts received which are related to cost periods prior to the provider's participation in the program and which have not been reflected in allowable costs under Medicare are not treated as reductions of costs.

CHAPTER 9

INPATIENT ROUTINE NURSING SALARY COST DIFFERENTIAL

INPATIENT ROUTINE NURSING SALARY COST DIFFERENTIAL

The inpatient routine nursing salary cost differential was adopted as an allowable cost in July 1969. Some early hospital studies indicated that aged patients (65 and over) receive more inpatient routine nursing care than the other patients. This results in more costly care for the aged on an average per day basis than the cost of care for the other patients.

In recognition of the above average cost of inpatient routine nursing care furnished to aged patients, the Medicare program allowed a cost differential as a reimbursable cost to the provider. The cost differential is called an inpatient routine nursing salary cost differential and became effective July 1, 1969, at the rate of 8 1/2 percent. In addition, in order to minimize additional cost finding, Medicare has equated the cost of nursing services in maternity and pediatric areas with the cost of nursing service provided to the aged.

An example later in this chapter will explain in more detail how this principle is implemented. However, before we get to the example, it will be helpful to define some of the technical terms used and to indicate what is and what is not included in inpatient routine nursing salary costs.

Aged day means a day of care rendered to an inpatient 65 years of age or older, whether or not the individual is a Medicare patient.

An aged day does not include a day of care rendered to an inpatient 65 years of age or older in an intensive care unit, coronary care unit, or other special care inpatient hospital units. The same rule applies to the definitions of pediatric days, maternity days, and inpatient days; these days do not include days in an intensive care unit, coronary care unit or other special care hospital units.

Pediatric day means a day of care rendered to an inpatient less than age 14 who is not occupying a bassinet for the newborn in the nursery.

Maternity day means a day of care rendered to a female inpatient admitted for delivery of a child.

Nursery day means a day of care rendered to an inpatient occupying a bassinet for the newborn in the nursery.

Inpatient day means a day of care rendered to any inpatient (except an individual occupying a bassinet for the newborn in the nursery).

Inpatient routine nursing salary cost includes only the gross salaries and wages of nurses and other personnel for nursing activities performed in nursing units not associated with the nursery nor associated with services for which a separate charge is customarily made. This cost includes gross salaries and wages of head nurses, registered nurses, licensed practical and vocational nurses, aides, orderlies, and ward clerks. It does not include salaries and wages of administrative nursing personnel assigned to the departmental office or nursing personnel who perform their work in surgery, central supply, recovery units, emergency units, delivery rooms, nurseries, employee health service, or any other areas not providing general inpatient care.

The salaries and wages of personnel performing maintenance or other activities that do not directly relate to the care of patients are excluded. Also excluded are payroll taxes, employee benefits, perquisites, maintenance, etc. Inpatient routine nursing salary cost does not include salaries or wages of nursing personnel assigned to an intensive care unit, coronary care unit, or other special care inpatient hospital units.

The adjusted inpatient routine nursing salary cost attributable to Medicare beneficiaries is determined on a per diem basis and is computed by dividing:

The total inpatient routine nursing service salary costs for all patients (excluding nursery and special care patients) plus 8 1/2 percent thereof, by the total inpatient days for all patients (excluding nursery and special care days) plus 8 1/2 percent of aged, pediatric, and maternity days.

The answer (quotient) is the adjusted average per diem inpatient routine nursing salary cost.

Adjusted per diem
inpatient routine
nursing salary cost

=

Inpatient routine
nursing salary (ex-
cluding nursery and
special care salary)
x 1.085

Total inpatient days
other than aged, pedi-
atric and maternity
(excluding nursery and
special care days) plus
aged, pediatric and
maternity days x 1.085

The inpatient routine nursing salary cost differential adjustment factor is determined on a per diem basis. It is the difference between the adjusted per diem inpatient routine nursing salary (excluding nursery and special care salary) cost and the average per diem inpatient routine nursing salary (excluding nursery and special care salary) cost for all patients.

Per diem differential
adjustment factor

=

Adjusted per diem in-
patient routine nursing
salary (excluding nurs-
ery and special care
salary) cost, minus av-
erage per diem inpatient
routine nursing salary
(excluding nursery and
special care salary)
cost

The number of Medicare patient days multiplied by the factor will indicate the additional cost reimbursable to the provider.

Example:

Inpatient routine nursing salary costs (excluding nursing salary costs of nursery and special care units)	\$ <u>160,000</u>
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Total inpatient days (excluding days for nursery and special care units)	12,800
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Total inpatient days applicable to Medicare* patients (excluding days in special care units)	3,840
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Total non-Medicare inpatient days applicable to aged, pediatric and maternity patients (excluding special care unit days)	<u>1,280</u>
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Total aged, pediatric, and maternity days (excluding special care unit days)	5,120
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* Assuming that all Medicare days are aged days

Computation

1. Adjusted per diem inpatient routine nursing salary cost (excluding nursing salary costs of the nursery and special care units)

$$\frac{\$160,000 \times 1.085}{(12,800 - 5,120) + (5,120 \times 1.085)} =$$
$$\frac{\$173,600}{(7,680) + (5,555)} = \frac{\$173,600}{13,235} = \$13.12$$

2. Average per diem routine nursing salary cost (excluding nursing salary costs of the nursery and special care units)

$$\frac{\$160,000}{12,800} = \underline{12.50}$$

3. Difference = per diem differential adjustment factor \$.62

4. Allowable general inpatient routine nursing salary cost differential applicable to Medicare patients

$$3,840 \text{ days} \times \$.62 \quad \underline{\underline{\$2,381.00}}$$

NOTE:

In 1975, a regulation was issued to eliminate the inpatient routine nursing salary cost differential for cost-reporting periods beginning after June 1975. However, a Federal district judge declared the regulation invalid and issued an injunction prohibiting the Secretary from terminating the differential, stating that further nursing utilization studies relating to patients aged 65 and older are required before any change can be justified. The inpatient routine nursing salary cost differential, therefore, continues to be in effect.

CHAPTER 10

DEPRECIATION

Methods of Depreciation

Funded Depreciation

Disposal of Depreciable Assets

Recovery of Accelerated Depreciation

Terminations Resulting from Transactions Between Related Parties

DEPRECIATION

Depreciation is defined by the American Institute of Certified Public Accountants as a "... system of accounting which aims to distribute the cost or other basic value of tangible capital assets, less salvage value, over the estimated useful life of the assets in a systematic and rational manner. It is a process of allocation of costs, not of valuation."

But in nonaccounting language, depreciation is the decrease in value of assets used in the business due to wear or obsolescence. Because it is not practical to measure exactly how much of a decrease in value occurred each year, the amount of depreciation is usually deducted uniformly over the life of the asset.

For example, a hospital x-ray machine which cost \$100,000 is expected to be used for ten years. Management estimates that at the end of the tenth year, the x-ray machine will be sold or scrapped for about \$5,000. Depreciation would be computed as follows:

Cost of x-ray machine	\$100,000
Salvage value, tenth year	<u>5,000</u>
Amount to be depreciated	\$ <u>95,000</u>
Depreciation:	$\$95,000 \div \text{ten years} = \$ \underline{9,500 \text{ per year}}$

Depreciation is an allowable cost on all depreciable assets that are used to provide covered services to Medicare patients. This includes assets that may have been fully depreciated on the books of the provider but are in use at the time the provider enters the program. The useful lives of such assets are considered not to have ended and depreciation calculated on a revised extended useful life is allowable.

In general terms, depreciable assets include buildings, building equipment, major moveable equipment, and minor equipment. (See the Provider Reimbursement Manual, Section 104ff for more detailed descriptions of these depreciable assets.)

Land is a nondepreciable asset, but land improvements such as paving, sewer and water lines, parking lots, etc., are depreciable.

Leasehold improvements made by the lessee to the leased property are subject to depreciation even though the improvements may become the property of the lessor after the expiration of the lease.

If a newly acquired depreciable asset has an estimated useful life of at least two years and a historical cost of at least \$300, it must be capitalized and written off over the estimated useful life of the asset, using one of the approved methods of depreciation.

Likewise, if depreciable assets are acquired in quantity and the cost of the quantity is at least \$500, the cost must be capitalized and written off over the estimated useful life of the asset.

The depreciable life of an asset is its expected useful life to the provider; not necessarily the inherent useful or physical life of the asset. The useful life is determined in the light of the provider's experience and the general nature of the asset and other pertinent data. Some factors for consideration are:

- (1) normal wear and tear,
- (2) obsolescence due to normal economic and technological advances,
- (3) climatic and other local conditions, and
- (4) providers' policy for repairs and replacement.

In projecting a useful life, providers are requested to follow the useful life guidelines published by the American Hospital Association (Chart of Accounts) or the Internal Revenue Service. A provider may use a different useful life, but the deviation must be based on convincing reasons accepted by the intermediary. Factors such as an expected earlier sale, retirement or demolition of an asset may not be used in a determination of the estimated useful life of an asset.

A composite useful life may be used for a class or group of assets.

The depreciation must be:

- (1) identifiable and recorded in the provider's accounting records,
- (2) based on the historical cost of the asset or the fair market value at the time of donation or inheritance in the case of donated or inherited assets, and
- (3) prorated over the estimated useful life of the asset using an allowable method of depreciation.

Historical cost is the cost incurred by the present owner in acquiring the asset and to prepare it for use, including freight and installation costs. The historical cost of assets under construction would include, in addition to the purchase price, architectural fees, consulting fees, and related legal fees.

For depreciable assets acquired after July 1970, the historical cost shall not exceed the lower of:

- (1) current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of the purchase, or
- (2) fair market value at the time of the purchase.

Fair market value is the price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition. Usually the fair market price will be the price at which bona fide sales have

been made for assets of like type, quality and quantity in a particular market at the time of acquisition.

An asset is considered donated when the provider acquires the asset without making any payment for it in form of cash, property, or services. When the provider makes any payment in acquiring the asset, then this payment, and not the fair market value, is considered to be the historical cost of the asset.

When an asset that has been used or depreciated under the program is donated to a provider, the basis for depreciation is the lesser of the fair market value or the net book value of the asset in the hands of the owner last participating in the program. The basis for depreciation is determined as of the date of the donation.

The same rule applies to an asset acquired through inheritance through testate or intestate distribution. For example, a widow inherits a skilled nursing facility upon the death of her husband. The basis for depreciation is determined as of the date of death, based on the lesser of the fair market value or the net book value of the asset.

Salvage value is the estimated amount expected to be realized upon the sale or other disposition of the depreciable asset when it is no longer useful to the provider. The amount is ordinarily estimated at the time of acquisition and is deducted from the cost of the depreciable property to arrive at the basis for depreciation. For example, an asset is purchased for \$17,000 with an expected salvage value of \$2,000; the basis for depreciation becomes \$15,000 -- i.e., \$17,000 less \$2,000 -- for computing the depreciation.

Thus, if a provider disposes of its assets when they are in good operating condition, the salvage value may be higher than it might be if the provider used the assets until their inherent life had been substantially exhausted.

If the provider is responsible for the cost of improvements under the terms of a lease, the cost of the improvements may be depreciated over the useful life of the improvement or the remaining term of the lease, whichever is shorter. The "remaining term of the lease" includes any period for which the lease may be renewed or extended or continued. The renewal or extension may be in the form of an option exercised by the provider. If there is no option, there must be a reasonable interpretation of past acts of the lessor and the provider pertaining to renewal.

METHODS OF DEPRECIATION

At the beginning of the Medicare program, there were three acceptable methods for prorating the cost of depreciable assets:

- (1) Straight-line method
- (2) Declining balance method
- (3) Sum-of-the-years-digit method

All three methods were acceptable for computing depreciation for cost reporting periods prior to August 1, 1970. For cost reporting periods after July 31, 1970, providers could no longer use accelerated depreciation methods (numbers 2 and 3 above) for newly acquired assets, they could use only the straight-line method.

Prior to August 1970, a provider could change from the straight-line method to an accelerated method, or vice versa, after receiving approval from the intermediary. The change had to be on a prospective basis, and the request had to be made before the end of the first month of the prospective reporting period. Only one such change with respect to a particular asset could be made by a provider.

After July 1970, if the provider wished to change the method of depreciation for assets acquired before August 1970, it could change only from the accelerated method to the straight-line method. Such a change can be made without intermediary approval. The basis for depreciation is the undepriciated cost of the asset reduced by the salvage value. The estimated life after a change is based on the remaining years of useful life. Once the straight-line method of depreciation is selected for a particular asset, an accelerated method of depreciation may not be used for that asset.

Under the straight-line method, the annual amount for depreciation is computed by dividing the cost of the asset less any estimated salvage value by the years of useful life. This method produces a uniform depreciation allowance each year.

$$\frac{\text{Cost of asset less salvage value}}{\text{number of years of useful life}} = \begin{array}{l} \text{Annual} \\ \text{allowance for} \\ \text{depreciation} \end{array}$$

Example:

Cost of new asset	\$ 17,000
Salvage value	2,000
Estimated useful life	5 years

$$\frac{\$17,000 - \$2,000}{5} = \frac{\$15,000}{5} = \begin{array}{l} \text{Depreciation:} \\ \$3,000 \text{ per year} \\ \text{for 5 years} \end{array}$$

Under the declining balance method, depreciation is computed by multiplying the undepriciated balance of the historical cost of the asset by a uniform rate. The uniform rate was limited to not more than double the straight-line rate.

Salvage value is not considered in computing the depreciation allowance under the declining balance method. However, under this method the asset should not be depreciated below the estimated salvage value.

Example:

Cost of new asset	\$17,000
Salvage value	3,000
Estimated useful life	5 years
Rate to be used	150% of the straight-line rate

5 year life:

Straight-line rate = 20%

20% X 150% = 30%

<u>Year</u>	<u>Undepreciated Balance</u>		<u>Rate</u>	<u>Annual Depreciation</u>
1	\$ 17,000	X	30%	\$ 5,100
2	11,900	X	30%	3,570
3	8,330	X	30%	2,499
4	5,831	X	30%	1,749
5	4,082	X	30%	1,082*
6	3,000			

* Depreciation amounted to \$1,225, but amount was reduced to \$1,082, to reflect the salvage value of \$3,000.

Under the sum-of-the-years' digit method the annual depreciation allowance is computed by multiplying the cost of the asset less estimated salvage value by a constantly decreasing fraction.

The numerator of the fraction represents the remaining years of useful life of the asset at the beginning of each year; the denominator represents the sum of the years of estimated useful life at the time the asset was acquired.

<u>Example:</u>	Cost of new asset	\$ 17,000
	Salvage value	2,000
	Estimated useful life	5 years

Computation:

Add the sum of the years of useful life.

5 years = 1+2+3+4+5 = 15

15 is the denominator of the fraction

For the numerator in each year, use the remaining years of useful life including the year for which depreciation is taken. (This means using each number in the sum of the years of useful life in reverse order, 5 for the first year, 4 for the second year, 3 for the third year, etc.)

Cost of asset	\$ 17,000
Salvage value	<u>2,000</u>
Basis for depreciation	\$ 15,000

<u>Year</u>	<u>Basis for Depreciation</u>		<u>Fraction</u>	<u>Annual Depreciation</u>
1	\$ 15,000	X	5/15	\$ 5,000
2	15,000	X	4/15	4,000
3	15,000	X	3/15	3,000
4	15,000	X	2/15	2,000
5	15,000	X	1/15	1,000

Because it can be a nuisance to compute the denominator under this method when an asset has a long life, say, 30 years, here is a mathematical short-cut:

$$\text{Denominator} = \frac{(\text{life})^2 + \text{life}}{2}$$

Example: using a 30-year life

$$\frac{30^2 + 30}{2} = \frac{900 + 30}{2} = \frac{930}{2} = 465 \text{ (Denominator in the fraction)}$$

Proof

$$\text{Add } 1+2+3+4 \dots +28+29+30 = 465$$

There is one exception to the rule that only straight-line depreciation may be used for assets acquired after July 1970. Providers may use a declining balance method not to exceed 150 percent of the straight-line method under certain conditions.

The conditions are that the providers must prove to the intermediary in writing that the cash flow for depreciation from the total depreciable assets (which are used to provide patient care services) is insufficient to supply the funds needed to pay the principal on the loans related to the provider's total depreciable assets (used to provide patient care services).

The intermediary must give written approval for each depreciable asset where a provider justifies the use of accelerated depreciation.

FUNDED DEPRECIATION

The allowance for depreciation is a "non-cash" item, i.e., the provider does not pay out cash to incur depreciation expense; nevertheless, the Medicare program reimburses the provider for depreciation on assets used to provide covered services. Theoretically, the amount of reimbursement received is earmarked to be used to replace the asset when it becomes fully depreciated although this does not always happen in actual practice.

Funding of depreciation is the practice of setting aside cash, or other liquid assets, in a fund separate from the general funds of the provider to be used for replacement of the assets depreciated, or for other capital purposes. The deposits to the fund are generally in an amount equal to the depreciation expense charged into costs each year.

Funding of depreciation by a provider may be required under the terms of a bond indenture, mortgage, or other lending agreement, in which the creditors restrict the use of such funds by the providers. In these situations, a trustee relationship is established by contract or agreement, wherein the provider is acting as a trustee in regard to the amounts required to be funded and the use of such funds as stipulated in the agreement.

A provider also may place self-imposed restrictions on the use of funds received equivalent to the depreciation expense for each period and voluntarily fund depreciation.

Although, Medicare does not require funding of depreciation, it strongly recommends that providers use this mechanism as a means of conserving funds for replacement of depreciable assets.

Where the provider funds depreciation, it is expected that money in the fund will be invested to earn revenues. Investment income earned by the funded depreciation account is not a reduction of allowable interest expense, and therefore, does not decrease the provider's costs. This provision should be an incentive for the funding of depreciation.

The provider may deposit in the Funded Depreciation Account the cumulative allowable depreciation expense, either in part or in total. Cumulative allowable depreciation is the total amount of depreciation from the date of acquisition. The allowable depreciation expense may be attributable to periods either before or after the provider's participation in the Medicare program. Hence, funding of such amounts is permitted even though depreciation expense applicable to a period prior to the provider's participation in the program is not an allowable cost.

Deposits representing depreciation must be in the funded depreciation account for six months or more to be considered as valid funding transactions.

When a provider borrows money to make deposits of funded depreciation, interest paid by the provider on the money borrowed for this purpose is not allowable as cost.

DISPOSAL OF DEPRECIABLE ASSETS

During the normal course of operations, depreciable assets may be sold, traded in for new assets, or scrapped, or the assets may be stolen or damaged in a fire or wreck or other casualty. When a depreciable asset has been disposed of, no more depreciation can be taken on the asset. In addition, any gain or loss must be computed and included in allowable cost.

However, where an asset has been retired from active service, but is being held for stand-by or emergency services, the provider may continue to take depreciation on such assets. Where the asset has been permanently retired or there is little likelihood that it can be used effectively in the future, no further depreciation can be taken on the asset, and gain or loss on the retirement must be computed.

When an asset is traded in for another asset, no gain or loss is recognized on the trade-in.

Where a provider (a) disposes of certain of its depreciable assets and continues to participate in the Medicare program, or (b) disposes of its depreciable assets, resulting in an effective termination of its participation in the program, or (c) stops participating in the program and subsequently disposes of its depreciable assets within one year after leaving the program, the gains and losses on the disposition of the depreciable assets are computed and included in the adjustment to Medicare reimbursable cost.

The computation involves recomputing the net book value of the asset to reflect the actual useful life of the asset. The actual useful life covers the period from the date the asset was acquired to the date of the disposal. This means that there is a net adjustment to depreciation using the actual life of the asset instead of the estimated life which was used when the asset was acquired originally.

The computation begins with subtracting the sales price of the asset (which is the actual salvage value) from the historical cost to determine the revised basis for depreciation. The revised basis is used to compute the adjusted depreciation applicable to the periods under the program. The net adjustment to depreciation on the disposition of depreciable assets also includes the depreciation adjustment on those assets acquired prior to entrance in the program.

The following examples are taken from Chapter 1 in the Provider Reimbursement Manual (PRM).

EXAMPLES

Facts Applicable to Examples 1 and 2 Below:

Provider entered the program 7/1/68

Historical Cost - 7/1/58	\$ 330,000
Estimated salvage value	<u>15,000</u>
Amount to be depreciated	\$ <u>315,000</u>
Estimated useful life	<u>30 years</u>
Actual useful life	
Asset acquired before entrance into the program - 7/1/58	10 years
Useful life under the program - asset sold 6/30/73	<u>5 years</u>
Total actual useful life	<u>15 years</u>

Depreciation taken before entrance into the program - (straight-line method)

$$\frac{(\text{Years - not under the program})}{(\text{Years - estimated useful life})} = \frac{10}{30} \times \$315,000 = \$105,000$$

Sales price - 6/30/73 \$ 183,000

EXAMPLE 1 - COMPUTATION OF NET DEPRECIATION ADJUSTMENT WHERE ACCELERATED DEPRECIATION WAS CLAIMED BY PROVIDER

Historical cost - 7/1/58	\$ 330,000
Actual salvage value - sales price 6/30/73	<u>183,000</u>
Basis for depreciation	\$ <u>147,000</u>

Depreciation adjusted for period not under the program

$$\frac{(\text{Years - not under the program})}{(\text{Years - actual useful life})} = \frac{10}{15} \times \$147,000 = \underline{98,000}$$

Depreciation adjusted for period under the program \$ 49,000

Depreciation taken under the sum-of-the-years digits method

$$\begin{aligned} \$315,000 - \$105,000 &= \$210,000 - 210 \text{ units}^* (20 \text{ years}) \\ \$1000 \times 90 \text{ units}^{**} (5 \text{ years}) &= \end{aligned} \quad \$ 90,000$$

Depreciation adjusted for the period under the program	<u>49,000</u>
Net depreciation adjustment - Excess depreciation taken	\$ <u>41,000</u>

* Sum of 1+2+3+4...+18+19+20 = 210 (Denominator)

** Sum of 20+19+18+17+16 = 90 (Numerator) This represents the five years of useful life under the program.

EXAMPLE 2 - COMPUTATION OF NET DEPRECIATION ADJUSTMENT WHERE STRAIGHT-LINE DEPRECIATION WAS CLAIMED BY PROVIDER

Historical cost - 7/1/58		\$ 330,000
Actual salvage value - sales price 6/30/73		<u>183,000</u>
Basis for depreciation		\$ 147,000
Depreciation adjusted for period not under the program		
(Years - not under the program)	10	x \$147,000 =
(Years - actual useful life)	<u>15</u>	\$ <u>98,000</u>
		<u>49,000</u>

Depreciation taken under the program - straight-line method

(Years - under the program)	5	x \$315,000 =	\$ 52,500
(Years - estimated useful life)	<u>30</u>		
Depreciation adjusted for period under the program			\$ <u>49,000</u>
Net depreciation adjustment - Excess depreciation taken			<u>\$ 3,500</u>

As for the treatment of casualty losses on depreciable assets, e.g., damage from a tornado, hurricane, earthquake, storm, fire, flood, accident, vandalism, etc., see Chapter 16, Insurance Against Losses.

RECOVERY OF ACCELERATED DEPRECIATION ON TERMINATION FROM THE PROGRAM

When a provider that has used an accelerated method of depreciation for any of its assets leaves the program after July 1, 1970, the amount of accelerated depreciation included in reimbursable cost in excess of the amount that would have been paid if the straight-line method of depreciation has been used must be recovered. The recovery of amounts paid in excess of straight-line depreciation is applicable to voluntary and involuntary terminations and to providers that change ownership.

The reason for this requirement is that under accelerated depreciation substantially larger amounts of depreciation are reimbursed during the early life of the asset and substantially smaller amounts during the latter years. It is not fair to the program to reimburse the provider with amounts in excess of straight-line depreciation during the early life of the depreciable asset and then to have the provider drop out of the program when the amount of reimbursable depreciation becomes less than straight-line depreciation.

When a provider ceases to participate in the program after July 1970, the adjustment to a straight-line depreciation applies to all cost reporting periods in which accelerated depreciation was claimed under the program. (There is one exception to this rule. An adjustment for amounts paid in excess of straight-line depreciation is not made where the cumulative total of Health Insurance (HI) days for all reporting periods in which the provider claimed accelerated depreciation is less than 5 percent of the cumulative total of inpatient days for the same reporting periods.)

The cost reporting periods to which a provider will allocate its total net depreciation adjustment depends on the following circumstances.

- 1) When the Medicare utilization is less than 5 percent of the cumulative total of inpatient days in the facility for all reporting periods in which depreciation on the asset disposed of was claimed under the Medicare program, or, the net depreciation adjustments applicable to all disposals of depreciable assets within the cost reporting period total \$5,000 or less, the provider must reflect the net depreciation adjustment as an adjustment of depreciation in the year of disposal.
- 2) Where the net depreciation adjustment is more than 5 percent of the cumulative total of inpatient days, or totals more than \$5,000, the provider must allocate the net depreciation adjustment to each reporting period. The basis for allocation is the ratio (percentage) of the depreciation allowed on the disposed assets to the total depreciation applicable in each reporting period.

The following example demonstrates how the net depreciation adjustment is allocated to each reporting period. As you can see, the net depreciation adjustment of \$41,000 is multiplied by the ratio of depreciation determined for each period.

Facts

Provider entered the program 7/1/68

Historical cost - 7/1/58	\$ 330,000
Estimated salvage value	<u>15,000</u>
Amount to be depreciated	\$ <u>315,000</u>
Estimated useful life	<u>30 years</u>
Actual useful life	
Asset acquired before entrance in to the program - 7/1/58	10 years
Useful life under the program - asset sold 6/30/73	<u>5 years</u>
Total actual life	<u>15 years</u>

Depreciation taken before entrance into the program - straight-line method

(Years - not under the program)	10	x	\$315,000	\$ 105,000
(Years - estimated useful life)	30			
Sales price - 6/30/73				\$ 183,000

COMPUTATION OF NET DEPRECIATION ADJUSTMENT WHERE ACCELERATED DEPRECIATION WAS CLAIMED BY PROVIDER

Historical Cost - 7/1/58				\$ 330,000
Actual salvage value - sales price 6/30/73				<u>183,000</u>
Basis for depreciation				\$ <u>147,000</u>
Depreciation adjusted for period not under the program				
(Years - not under the program)	10	x	\$147,000	\$ <u>98,000</u>
(Years - actual useful life)	15			
Depreciation adjusted for period under the program				\$ <u>49,000</u>
Depreciation taken under the program (sum-of-the-years' digits method)				
\$315,000 - \$105,000 = \$210,000 ÷ 210				
units (20 years) = \$1,000 x 90 units (5 years) =				\$ 90,000
Depreciation adjusted for the period under the program				<u>49,000</u>
Net depreciation adjustment - Excess depreciation taken				\$ <u>41,000</u>

Allocation of Net Depreciation Adjustment to Each Reporting Period Under the Program

<u>Cost Report Period Ending</u>	<u>Disposed Asset Depreciation (Per Cost Report)</u>	<u>Percent (ratio) of Reporting Period Depreciation to Total Depreciation</u>	<u>Allocation of Net Depreciation Adjustment</u>
6/30/69	\$ 20,000	22% of \$41,000	\$ 9,020
6/30/70	19,000	21% of \$41,000	8,610
6/30/71	18,000	20% of \$41,000	8,200
6/30/72	17,000	19% of \$41,000	7,790
6/30/73	16,000	18% of \$41,000	7,380
Total	\$ 90,000	100	\$41,000

Decrease in Health Insurance (HI) Percentage of Allowable Cost

The same rule applies, i.e., accelerated depreciation must be recovered for periods beginning after July 1, 1970, when the number of Medicare patients has decreased substantially. A decrease in the number of Medicare patients results in a decrease in the health insurance (HI) percentage of the allowable costs so that cumulatively substantially more depreciation was paid to the provider than would have been paid under the straight-line method.

If a provider has experienced a decrease in its health insurance percentage of allowable costs as defined below, a recovery of amounts paid in excess of straight-line depreciation is made. The recovery is made for all cost reporting periods in which accelerated depreciation was claimed, except the computation period.

A recovery of amounts paid in excess of straight-line depreciation is made where the provider's ratio (percentage) of health insurance days to total inpatient days (certified areas only) has decreased 25 percent or more from the base period to the computation period.

A recovery of amounts paid in excess of straight-line depreciation due to a decrease in HI utilization is not made where the cumulative total of HI days in the base period is less than 5 percent of the cumulative total of inpatient days in the facility (certified areas only).

Base Periods

The initial base period for the recovery of amounts paid in excess of straight-line depreciation includes one or more cost reporting periods beginning with the provider's first cost reporting period starting after July 1970, and including all cost periods thereafter, except the computation period.

Computation Period

The computation period is defined as the provider's current cost reporting period starting after July 1971.

The subsequent base period after a recovery of amounts paid in excess of straight-line depreciation, begins with the first cost period after the end of the prior base period and all cost periods thereafter, except the current computation period.

Example:

Comparison of Ratio of HI Utilization in Computation Period to HI Utilization in Base Period — (Provider entered program 1/1/67)

<u>Fiscal Year Ending (FYE)</u>	<u>Total Inpatient Days</u>	<u>Total HI Days</u>
12/31/71	72,000	17,280
12/31/72	72,727	16,000
12/31/73	80,000	8,000

1. First Computation Period — FYE 12/31/72

Base period ratio: percent of HI days to total inpatient days
(FYE 12/31/71) $(17,280 \div 72,000)$ 24%

Computation period ratio - current year's percent of HI days
to total inpatient days (FYE 12/31/72) $(16,000 \div 72,000)$ 22%

Decline in HI ratio - (Base period ratio less computation
period ratio) 2%

Percentage of Decline in HI Participation

$$\frac{\text{Decline in HI ratio}}{\text{Base period ratio}} = \frac{2}{24} = 8\%$$

As the ratio of HI utilization in the computation period has not decreased 25% or more from the HI utilization in the base period, no adjustment is necessary.

2. Second Computation Period — FYE 12/31/73

Base period ratio: percent of HI days to inpatient days (FYE
12/31/71 + FYE 12/31/72) $(33,280 \div 144,727)$ = 23%

Computation period ratio - current year's percent of HI days
to total inpatient days (FYE 12/31/73) $(8,000 \div 80,000)$ 10%

Decline in HI ratio - (Base period ratio less computation
period ratio) 13%

Percentage of Decline in HI Participation

$$\frac{\text{Decline in HI ratio}}{\text{Base period ratio}} = \frac{13}{23} = \underline{\underline{56\%}}$$

As the ratio of HI utilization in the computation period had decreased more than 25% from the HI utilization in the base period, a computation to determine if there has also been a decrease of 25% or more in the number of HI days must be made.

Base period - average number of HI days

$$(17,280 + 16,000) = (33,280 \div 2) = 16,640 \text{ days}$$

Computation period - actual number of HI days 8,000 days

Decrease in number of HI days 8,640 days

Percentage of decrease in number of HI days:

$$\frac{8,640}{16,640} = 52\%$$

As there has been a decrease of 25% or more in both the number of HI days and HI utilization, an adjustment to recover amounts paid in excess of straight-line depreciation must be made.

(See Section 136.4 in the Provider Reimbursement Manual (PRM) for additional details and instructions.)

TERMINATIONS RESULTING FROM TRANSACTIONS BETWEEN RELATED PARTIES

The recovery of accelerated depreciation will not be made when all four of the following conditions are met:

1. The termination of the provider agreement is due to a change in ownership of a provider resulting from a transaction between related parties,
2. The successor organization participates in the program,
3. Control and the extent of the financial interest of the owners of the provider before and after the termination remain the same, and
4. All assets and liabilities of the terminated provider are transferred to the related successor provider.

Examples of transactions that result in a termination of one provider agreement and the establishment of another, but which do not require a recovery of accelerated depreciation include, but are not limited to:

1. A merger of a wholly-owned subsidiary corporated provider into the parent corporation or into another wholly-owned subsidiary corporation of the parent corporation;
2. A consolidation of two or more corporate providers forming a new corporate provider;
3. the incorporation of a sole proprietor or partnership with stock ownership in the same ratio as the prior proprietary interest;
4. The transfer of a provider operated as a branch of the parent corporation to a wholly-owned subsidiary; or
5. A change in organizational structure from a solely-owned corporation to a sole proprietorship.

In such cases, the recovery of accelerated depreciation is not applied, but rather the transaction is treated as follows:

1. the net book value of the assets, the liabilities related to the assets, and the method of depreciation as recorded on the books of the terminated provider must be used by the successor provider;

2. the successor provider must record the historical cost and accumulated depreciation of the terminated provider recognized under the program and these are considered as incurred by the successor provider for program purposes, such as gain or loss on any subsequent disposition of assets or recovery of accelerated depreciation;
3. the HI utilization of the terminated provider is considered as incurred by the successor provider for purposes of determining whether there has been a decrease in the Medicare percentage of allowable costs; and
4. the equity of the successor provider as of the beginning of the first cost reporting period must be the same as the equity capital of the terminated provider as of the closing of the final cost report.

To assure that the intermediary is cognizant of all pertinent facts, an officer of the successor provider must furnish a statement to the intermediary concerning the transaction in relation to these four elements at the time the new provider agreement is entered into.

CHAPTER 11

LEASES, LEASE/PURCHASE AGREEMENTS,

SALES AND LEASEBACK

LESSOR/LESSEE ARRANGEMENTS

Owners of some facilities enter into agreements providing for leasing a stated number of beds in their institutions. Under these arrangements, the lessor-operator (owner) of the facility agrees to provide the equipment, furnishings, supplies, meals, maintenance and janitorial services necessary for the lessee's operation of a portion of the premises, usually as a skilled nursing facility under the Medicare program. The lessor (owner) usually provides all necessary nursing services, or at least provides an option for the lessee to use the lessor's nursing services. The arrangements vary widely in their provisions. However, from the standpoint of patient care, there is apparently little difference in the manner that medical care would actually be provided whether or not a leasing arrangement existed.

The lease usually provides for a rental payment that is not representative of the actual costs of the services furnished. In most cases, the rental payment closely approximates or exceeds the facility's normal charges. The rental amount may be stated in a variety of ways: the lessor's normal charges; a modification of the standard charges representing a stipulated reduction; a monthly rental per bed plus a supplemental payment for general overhead and the purchase at predetermined rates of specific services such as meals, laundry, medical supplies, and all the usual ancillary services such as drugs, physical therapy, etc.; and many other variations.

Regardless of the parties' motivations for entering into such an agreement, the result of the transaction is to guarantee the lessor (owner) a return on a charge basis for providing facilities and services, whether or not utilized by program beneficiaries. Such a result is not in accord with the requirement of the law that the program reimburse providers on the basis of the reasonable cost of services to program beneficiaries.

Where an entire facility or a skilled nursing facility distinct-part has been leased by a provider under an arrangement whereby the lessor operates and furnishes essential services, and the lease requires payments to the lessor that are not representative of the actual cost of the facilities or services furnished by the lessor, the program will not recognize such payments for reimbursement purposes. The program will reimburse the lessee only on the basis of the lessor's reasonable costs of furnishing the facilities and services and any other reasonable costs attributable to the lessee's actual services.

LEASE/PURCHASE AGREEMENTS

Some lease agreements are essentially the same as installment purchases of facilities or equipment. The existence of the following conditions will generally establish that a lease is a virtual purchase:

- (1) the rental charge exceeds rental charges of comparable facilities or equipment in the area;
- (2) the term of the lease is less than the useful life of the facilities or equipment; and

- (3) the provider has the option to renew the lease at a significantly reduced rental, or the provider has the right to purchase the facilities or equipment at a price which appears to be significantly less than what the fair market value of the facilities or equipment would be at the time acquisition by the provider is permitted.

If the lease is a virtual purchase, the rental charge is includable in allowable costs only to the extent that it does not exceed the amount which the provider would have included in allowable costs if the provider had legal title to the asset. This means the allowable costs are the same as the costs allowed to owners, e.g., straight-line depreciation, insurance, interest and property taxes.

Accelerated depreciation on these assets may not be included in allowable costs under any circumstances. The difference between the amount of rent paid and the amount of rent allowed as rental expense is considered a deferred charge and is capitalized as part of the historical cost of the asset when the asset is purchased. If the asset is returned to the owner, instead of being purchased, the deferred charge may be expensed in the year the asset is returned.

Some providers lease their facilities from municipalities at a nominal rental — usually for \$1.00 per year -- the lease generally covering the useful life of the facility. Under most lease arrangements, the tenant (lessee) maintains the property and pays the cost of any improvement or addition to the facility. When such improvement or addition is made the lessee may properly amortize its cost. The amortization allowance is includable in allowable cost. At the end of the lease, improvements and additions made by the lessee become the property of the lessor.

("Amortization" is the technical accounting term for depreciation of intangibles, in this case, the lease between the provider and the municipality. In accounting language, depreciation is the term used for plant assets, depletion for wasting assets such as mines, oil wells, etc., and amortization for intangibles.)

SALES AND LEASEBACK AGREEMENTS

A "sale and leaseback" is a technical term used to describe a financing transaction where improved property is sold but taken back by the seller for use on a long-term lease. Usually, such transactions have some income tax advantages.

Where a provider enters into a sale and leaseback agreement with a nonrelated purchaser involving plant facilities or equipment, the incurred rental specified in the agreement is includable in allowable costs if the following conditions are met:

1. The rental charges are reasonable based on consideration of rental charges of comparable facilities and market conditions in the area; the type, expected life, condition and value of the facilities or equipment rented and other provisions of the rental agreements;

2. Adequate alternative facilities or equipment which would serve the purpose are not or were not available at lower cost; and
3. The leasing was based on economic and technical consideration.

CHAPTER 12

INTEREST EXPENSE

Provider's Unrestricted Funds

Provider's Restricted Funds

Interest Expense During Periods of Construction

Interest on Bonds

Government Bond Issues



INTEREST EXPENSE

Interest is the cost incurred for the use of borrowed funds, generally paid at fixed intervals by the borrower. Providers borrow money for working capital needed for normal operating expenses, or to purchase equipment or buildings, or to construct new facilities or other capital improvements.

The interest must be incurred on a loan which is necessary and proper for the operation, maintenance, or acquisition of the provider's facilities. The loan must be reasonably related to patient care.

The rate of interest must be no more than a prudent borrower would have to pay in the money market when the loan was made. The loan must be made from a lender not related to the provider through common ownership or control.

The loan must be supported by evidence that funds were actually borrowed and that payment of interest and repayment of the funds are required. The loan must be identifiable in the provider's accounting records, and the interest must be related to the cost reporting period in which the costs are incurred. The loan must be necessary and proper for the operation, maintenance, or acquisition of the provider's facilities.

Interest is an allowable expense on short-term loans (one year or less) and on long-term loans (more than one year).

Where funds are borrowed by the provider to invest in other than the provider's operations, the interest expense is not allowable; such a loan is not considered "necessary." For example, if the provider participates in the program as a hospital and borrows funds to buy or construct a skilled nursing facility, the loan would be considered as an investment in other than the provider's operations, and the interest would not be allowable.

When borrowed funds create excess working capital, interest expense on such loans is not an allowable cost.

Medicare rules require that interest expense be reduced by investment income. However, there is an exception to this general rule where the investment income is from grants and gifts (whether restricted or unrestricted), which are not commingled with other funds. "Not commingled" means that the funds are kept physically apart in a separate bank account or in a separate investment; funds which are simply recorded separately in the provider's accounting records would not qualify for this exception.

Provider's Unrestricted Funds

Frequently, a provider receives gifts and grants to be used for any purpose management determines to be appropriate. These gifts and grants are unrestricted in that the donor has not indicated a particular use to which the donation must be applied. Sometimes, the provider does not use these funds immediately. In such cases, monies may be "funded," or placed in a physically segregated account and retained until the provider decides to use them.

Where unrestricted funds are used to make "loans" to the general funds of the provider for use in current operations, or for other purposes, interest paid

by the general fund to the unrestricted fund is not allowable as a cost. Unrestricted funds are available for the use of the provider, and the provider should use them rather than "borrow" these available funds and pay interest to itself. The same treatment applies to funds created by the provider's restricting its own funds for particular management purposes.

Where the provider has invested funds from gifts or grants which are unrestricted as to use, and these funds are commingled with other funds, the provider's allowable interest expense is reduced by the amount of the investment income earned by the fund.

Any investment income in excess of interest expense should not be used to offset other operating expenses.

Provider's Restricted Funds

Providers sometimes receive a gift or grant from a donor who specifies that it is to be used for a specific purpose. When a provider accepts such restricted funds from a donor, a trustee relationship is established wherein the provider is acting as a trustee for the donor in regard to the funds donated and the provider is bound by the conditions set forth by the donor. This is a "restricted" gift or grant and must be used for the designated purpose. Where the proceeds of a donor-restricted grant or gift are placed in a fund to be retained until it may be used, the fund is known as a restricted fund.

Where a provider's donor-restricted funds make loans to the general fund of the provider, the interest paid by the general fund to the restricted fund is an allowable cost. Since these funds are not available for use by the provider except as designated, it is expected that the provider would invest them until they are used. For this reason, interest is allowable if the funds are loaned to the general fund.

If these funds are borrowed for construction purposes, the interest earned by the funds would not be applied as a reduction of interest expense. The interest paid to the fund during the period of construction is capitalized as part of the cost of construction and recovered as allowable depreciation.

Where the provider has invested donor-restricted funds and these funds are not commingled with other funds, the investment income from such funds does not reduce the allowable interest expense of the provider.

If restricted funds are commingled with the provider's other funds, the investment income earned on the fund does reduce allowable interest expense. In a common fund, restricted funds lose their identity and all earnings are applied as a reduction of allowable interest expense.

As mentioned previously, the loan must be made from a lender not related to the provider through control, ownership or personal relationship. This provision is intended to assure that loans are legitimate and needed, and that the interest rate is reasonable.

Generally, interest paid to partners, owners, stockholders or related organizations of the provider is not allowable as a cost. Where the owner uses his own funds in a business, the funds are considered invested funds or capital rather than borrowed funds; the loan is considered as part of the equity capital of the provider.

There are two exceptions to this general rule. One is where interest is paid to a partner, owner, stockholder, or related organization on loans made prior to July 1, 1966, the interest is allowable but only if the terms and conditions of payment of such loans have not been changed or modified after June 30, 1966.

The other exception is for providers owned and operated by religious orders, where the providers borrow from the Mother House. Interest on such loans is allowable if there is a contractual agreement for the payment of interest and for the eventual repayment of the loan.

Where a provider leases facilities from a related organization and the rental expense paid to the related organization is not allowable as a cost, costs of ownership of the leased facility are allowable costs of the provider. Therefore, in such cases, the mortgage interest which relates to the leased facility paid by the related organization is allowable as an interest cost to the provider. (As you know, mortgage interest is considered to be a cost of ownership.)

Where a provider borrows from its own restricted fund, interest paid to the restricted fund by the general fund is an allowable cost but at a rate not to exceed the rate of interest the restricted fund is currently earning.

Where a provider borrows funds to finance the purchase of a facility or a tangible asset after July 1970, certain restrictions apply. If the purchase price exceeds the historical cost or the cost basis, the interest expense on that portion of the loan used to finance the excess cost is not allowed because it is not considered reasonably related to patient care. Medicare requires that the cost basis of depreciable assets acquired after July 1970 shall not exceed the lower of the current reproduction cost, adjusted for straight-line depreciation over the life of the assets to the time of the sale, or the fair market value of the tangible assets purchased.

Interest Expense During Period of Construction

Frequently, providers may borrow funds to construct facilities or to enlarge existing facilities. Usually, construction of facilities will extend over a long period of time, during which interest costs on the loan are incurred. Interest costs incurred during the period of construction must be capitalized as a part of the cost of the facility. The period of construction is considered to extend to the date the facility is put into use for patient care.

If the construction is an addition to an existing facility, interest incurred during the construction period on funds borrowed to construct the addition must be capitalized as a cost of the addition. After the construction period, interest on the loan is allowable as an operating cost.

Where a bond issue is involved, any bond discount and expense, or bond premium amortized during the period of construction, is included in the capitalized cost of the facility constructed.

Interest on Bonds

A bond is an instrument used by both corporations and government entities to borrow funds, usually for long-term capital requirements. A bond is evidence

of a liability and bondholders are assured of repayment at some future dates. The terms of the bond are stated in the bond indenture and interest is usually stated as a fixed rate payable in periodic payments such as semi-annually. Interest on bonds is an allowable cost in accordance with the terms of the bond indenture, to the extent that the interest relates to bond proceeds used either to acquire assets for use in patient care activities or to provide funds for operations related to patient care.

Government Bond Issues

Many providers, particularly hospitals, are owned and operated by Federal, State, and local governments. The facilities are constructed or acquired with funds raised by the governmental entity. Governments at all levels, raise funds for operating and capital expenditures by levying taxes and by borrowing through the device of issuing bonds.

Interest costs are allowable on those governmental bond issues specifically designated for the construction or acquisition of a provider's facility but only where the facility is owned by and the provider is controlled by the governmental entity issuing the bonds. Under this principle, "governmental entity" refers to a level of government, i.e., Federal, State, county or city, rather than a department or agency of a level of government.

In many instances, governmental bond issues are designated to meet the construction costs for more than one facility. In such cases, the portion of the interest costs on these bonds applicable to a provider facility is an allowable cost where the facility is owned by and the provider is controlled by the governmental entity issuing the bonds.

General Purpose Government Bond Issues

In some cases, the funds used to construct or acquire the governmental facilities are obtained from the "general purpose funds" of the government-owner. Even though a portion of such funds to construct or acquire the facility is raised through bond issues, no part of the interest payable on the bonds is allowable as a cost of the provider.

CHAPTER 13

BAD DEBTS, CHARITY, AND COURTESY ALLOWANCES

Effect of Waiver of Liability Provision

Recovery of Bad Debts

Methods of Determining Bad Debts

Charity, Courtesy, and Third-Party Allowances

Credit Card Costs

Allowances to Employees

BAD DEBTS, CHARITY AND COURTESY ALLOWANCES

The general accounting principle is that bad debts, charity and courtesy allowances "are deductions from revenue and are not to be included in allowable costs." This means that bad debts, charity and courtesy allowances are not considered by Medicare to be allowable costs of the provider which can be subtracted from the provider's income. Instead, Medicare considers that the provider has simply not received some of the fees it has charged to non-Medicare patients.

However, bad debts attributable to Medicare deductibles and co-pay amounts are reimbursable as costs to the provider. The allowance of unrecovered costs attributable to such bad debts results from the expressed intent of Congress that the costs of services covered by the program will not be borne by individuals not covered, and the costs of services not covered by the program will not be borne by the program.

Medicare patients are responsible for the payment of deductibles and co-pay amounts. When the provider cannot collect these amounts from Medicare patients, their part of the costs of covered services is borne by other patients who are not Medicare patients.

Therefore, to assure that costs of covered services are not borne by others because Medicare beneficiaries do not pay their deductibles and co-pay amounts, the Medicare program will reimburse the provider for allowable bad debts, not to exceed the total amount of unrecovered costs of covered services furnished to all Medicare patients. In the determination of unrecovered costs due to bad debts, the Medicare program is considered as a whole without distinction between Part A and Part B of the program.

Definitions

Bad debts are amounts considered to be uncollectible from accounts receivable and notes receivable which were created or acquired in providing services.

Allowable bad debts are bad debts of the provider resulting from uncollectible Medicare deductibles and co-pay amounts. Allowable bad debts must relate to specific deductibles and co-pay amounts.

Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient.

Courtesy allowances are reductions in charges by the provider in the form of an allowance to physicians, clergy, members of religious orders, and others, as approved by the governing body of the provider, for services received from the provider. Reductions in charges made as employee fringe benefits, such as hospitalization and personnel health programs are not considered courtesy allowances.

Deductible and co-pay amounts are amounts payable by Medicare patients for covered services received from providers of services, excluding medical and surgical services rendered by physicians and surgeons. These deductibles and co-pay amounts, including the blood deductible, must relate to inpatient hospital services, post-hospital skilled nursing facility care services, home health services, outpatient services, and medical and other health services furnished by a provider of services.

If a Medicare patient does not pay for services which are not covered by Medicare, the bad debts attributable to these services are not reimbursable under the Medicare program. Likewise, bad debts arising from services to non-Medicare patients are not reimbursable under the program.

Criteria for Allowable Bad Debts

A debt must meet these criteria to be an allowable bad debt:

1. The debt must be related to covered services and derived from deductible and co-pay amounts;
2. The provider must be able to show that reasonable collection efforts were made;
3. The debt was actually uncollectible when claimed as worthless; and
4. Sound business judgment established that there was no likelihood of recovery at any time in the future.

To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and co-pay amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort.

A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. If a collection agency is used, the provider need not refer all uncollected patient charges to the agency; it may refer only uncollected charges above a specified minimum amount. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient.

Where a provider utilizes the services of a collection agency, the fees the collection agency charges the provider are recognized as an allowable cost of the provider. When a collection agency obtains payment of an account receivable, the full amount collected must be credited to the patient's account and the collection fee charged to administrative costs. For example, where an agency collects \$40 from the beneficiary, and its fee is 50 percent, the collection agency keeps \$20 as its fee for the collection services and remits \$20 (the balance) to the provider. The provider records the full amount collected from the patient by the agency (\$40) in the patient's account receivable and records the collection fee (\$20) in administrative costs. The fee charged by the collection agency is a charge for providing the collection service, the collection agency's fee is not treated as a part of the bad debt.

Indigent or Medically Indigent Patients

In some cases, the provider may have established before discharge, or within a reasonable time before the current admission, that the beneficiary is either indigent or medically indigent. The provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines:

1. The patient's indigence must be determined by the provider, not by the patient, i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigency;
2. The provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses;
3. The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill, e.g., Title XIX, local welfare agency, or guardian; and
4. The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.

Once indigence is determined and the provider concludes that there has been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible.

Accounting Period for Bad Debts

Uncollectible deductibles and co-pay amounts are recognized as allowable bad debts in the reporting period in which the debts are determined to be worthless. Allowable bad debts must be related to specific amounts which have been determined to be uncollectible. Since bad debts are uncollectible accounts receivable and notes receivable, the provider should have the usual accounts receivable records, ledger cards, and source documents to support his claim for a bad debt for each account included.

Effect of the Waiver of Liability Provision on Bad Debts

1. Beneficiary Liability -- The waiver of liability provision of the law protects a beneficiary (Medicare patient) from liability for payments to a provider for noncovered services when:
 - a. The services are found to be not reasonable and necessary or to involve custodial care, i.e., the services are not covered; and
 - b. The beneficiary did not know or could not reasonably be expected to have known that the services were not covered.

2. Provider Not Accountable -- The program will reimburse the provider for the services if the provider did not know and could not reasonably be expected to have known that the services were not covered and the beneficiary had no knowledge as described in paragraph 1. If the provider has such knowledge, the provider will assume accountability for the noncovered services.

Where neither the provider nor the beneficiary is found accountable, the provider's charges for the services and the patient days are recorded as Medicare charges and Medicare patient days. The provider is entitled to collect from the beneficiary the amounts that would have represented the deductible and co-pay amounts. If these amounts are not collected, they can be reimbursed under the Medicare bad debt provision since the effect of the waiver of liability provision is to reimburse the provider as it would have been reimbursed had the services been covered.

3. Provider Accountable -- Where the provider is found accountable, any bad debts the provider experiences from such a program decision cannot be reimbursed under the Medicare bad debt provision. Provider costs attributable to these noncovered services furnished a beneficiary where the beneficiary's liability to the provider has been waived must be included in provider's total costs for cost report purposes. The provider's charges for the services and the patient days must be shown as non-Medicare charges for the services and non-Medicare patient days.

The provider is nevertheless entitled to collect from the beneficiary the amounts that would have represented the deductible and co-pay amounts had the services been covered. If these amounts are not collected, however, they cannot be reimbursed under the Medicare bad debt provision since they apply to services held to be not covered.

Recovery of Bad Debts

Sometimes amounts which were included in allowable bad debts in a prior period are recovered in later reporting period. Treatment of such recoveries is as follows:

Where the provider has allowable bad debts in the reporting period in which the previous bad debts were recovered, reimbursable costs in that period are reduced by the amounts recovered. However, such reduction in reimbursable costs should not exceed the amount of bad debts allowed to the provider in the prior period.

For example, assume that in 1977 the provider claimed \$100 in bad debts but the Medicare program allowed only \$80 in bad debts. In 1979, the provider recovered \$90 of the 1977 bad debts. No more than \$80 (the amount allowed by Medicare in 1977) can be used to offset bad debts in 1979.

If the provider had not been reimbursed for any bad debts in 1977 by the Medicare program, no part of the \$90 recovered in 1979 would be used to offset bad debts.

Methods of Determining Bad Debt Expense

Under the direct charge-off method, accounts receivable are analyzed and a determination made as to specific accounts which are deemed uncollectible. The amounts deemed to be uncollectible are charged to an expense account for uncollectible accounts.

The amounts charged to the expense account for bad debts should be adequately identified as to those which represent deductible and co-pay amounts applicable to Medicare patients and those which are applicable to other patients or which are for other than covered services. Those bad debts which are applicable to Medicare patients for uncollectible deductible and co-pay amounts are included in the calculation of reimbursable bad debts.

Under the reserve method, providers estimate the amount of bad debts that will be incurred during a period, and establish a reserve account for that amount. The amount estimated as bad debts does not represent any specific debts, but is usually based on a percentage of the total of receivables or services.

Bad debt expenses computed by use of the reserve method are not allowable bad debts under the program. However, any specific uncollectible deductible and co-pay amounts applicable to Medicare patients and charged against the reserve are includable in the calculation of reimbursable bad debts.

Medicare Bad Debts Under State Welfare Programs

Effective January 1, 1968 (as a result of the 1967 Amendments to the Social Security Act), State Title XIX plans may choose not to pay for the full Part A deductible and co-pay amounts for the medically needy. In such cases, the amount of the beneficiary's liability is determined by the State. To the extent that the State plans do not provide for payment of the Medicare deductible and co-pay amounts for medically needy patients eligible for Title XIX benefits, such unpaid amounts are allowable as bad debts.

Where a State plan under Title XIX provides that the State will pay all, or any part, of the deductible or co-pay amounts under Part A, the portion that the State will pay is not allowable as a bad debt under Medicare.

Where the State is not participating under Title XIX but State or local law requires the welfare agency to pay the deductible and co-pay amounts, any such amounts unpaid by the Medicare patient are not includable in allowable bad debts.

Where neither the Title XIX plan nor State or local law requires the welfare agency to pay the deductible and co-pay amounts, there is no program requirement that the State be responsible for these amounts. Therefore, any such amounts uncollectible from the Medicare patient under Part A or Part B are includable in allowable bad debts.

Charity, Courtesy, and Third-Party Payer Allowances

Charity, courtesy, and third-party payer allowances are not reimbursable Medicare costs. Charges related to services subject to these allowances should be recorded at the full amount charged to all patients, and the allowances should be appropriately shown in a revenue reduction account. The

amount reflecting full charges must then be used as applicable to apportion costs (RCC method) and in determining customary charges for application of the lower of costs or charges provision.

Example: The provider entered into an agreement with a third-party payer to render services at 25 percent below charges. Accordingly, for an x-ray service with a charge of \$40, the provider billed the third-party payer \$30. The charge of \$40 would be used to apportion costs and the \$10 allowance would be recorded in a revenue reduction account.

Credit Card Costs

Charges made by credit card organizations to a provider should be treated as reductions to income and may not be included in allowable costs. The provider, by adopting a credit card plan, accepts a reduction in revenue from a specific category of patients (credit card holders).

A reduction in income due to a credit card plan is appropriately classified as a courtesy or contractual allowance.

Note: As stated previously, the reductions in amounts received should have no effect on the charge data used in determining the ratio of Medicare patient charges to total patient charges in the apportionment of allowable costs.

Allowances to Employees

Allowances, or reductions in charges granted to employees for medical services are considered as fringe benefits related to employment, not as courtesy allowances.

The allowances themselves are not costs since the costs of the services rendered are already included in the provider's costs.

(See Section 332.lff in the Provider Reimbursement Manual for examples and specific instructions.)

CHAPTER 14

GRANTS, GIFTS, AND INCOME FROM ENDOWMENTS

Restricted Grants, Gifts, and Income from Endowments

Unrestricted Grants, Gifts, and Income from Endowments

Public Health Service Grants

Seed Money Grants

GRANTS, GIFTS, AND INCOME FROM ENDOWMENTS

Unrestricted grants, gifts, and income from endowments are funds, cash or otherwise, given to a provider without restriction by the donor as to their use.

Restricted or designated grants, gifts, and income from endowments are funds, cash or otherwise, which must be used only for a specific purpose designated by the donor.

Unrestricted grants, gifts, and income from endowments are not deducted from costs in computing allowable costs. These funds are considered the property of the provider to be used as it deems appropriate. These funds generally give the provider a means of recovering costs which are not otherwise recoverable, such as costs related to bad debts of patients not covered by Medicare.

Restricted grants, gifts, and income from endowments which are designated by the donor for paying certain provider operating costs, or costs of specific groups of patients, are deducted from the designated costs or group of costs. Where the designated cost covers services rendered to all patients, including Medicare beneficiaries, operating costs applicable to all patients are reduced by the amount of the restricted grants, gifts, or income from endowments, thus resulting in a reduction of allowable costs.

For example, if a specific donation were made to cover the costs of medical social services for all patients, the costs of medical social services would be reduced by the amount of the donation to arrive at allowable costs.

The terms of the contribution may specifically state the period of time during which the funds are to be applied. Where such specific periods of time are not provided, restricted contributions are deemed to be used in the reporting period in which the gift is received to the extent that applicable costs are incurred after the date of the gift. Generally, the donor of a restricted contribution intends that the provider use the funds for the purpose for which they were given as opportunities occur for such use. Restricted contributions not used in the reporting period in which they were received are carried over into the following period, or periods, and used for the designated purpose.

For example, assume that a provider incurred \$12,000 cost for medical social services during a calendar year reporting period. On July 1, he received a contribution of \$10,000 which was designated by the donor to be used to provide medical social services for all patients. Examination of the costs of these services indicates the costs of \$4,000 were incurred after July 1. Under the principles of reimbursement, allowable costs would be computed as follows:

Total costs of medical social services for the reporting period:	\$ 12,000
Portion of such costs incurred after the date of the gift:	<u>4,000</u>
Allowable costs of medical social services for the reporting period: -	\$ 8,000

The amount of the restricted contribution would be adjusted as follows:

Contribution as of July 1:	\$ 10,000
Costs appropriate to use of funds incurred subsequent to date of gift:	<u>4,000</u>
Balance of restricted contribution at end of reporting period:	\$ <u>6,000</u>

This balance would be applied to the costs incurred for medical social services during the subsequent reporting periods.

Whether or not they are characterized as a "grant" or a "gift," funds transferred to a provider from another component of the same organizational entity, e.g., from a university to the university hospital or from a State agency to a State university hospital, are not considered a grant or gift for Medicare reimbursement purposes. Such grants or gifts are considered to be an internal transaction in which there is a self-financing of the entity's own component operations, thus having no effect on the provider's allowable costs.

However, such funds are considered a grant or gift where the component from which the funds are received is not one which exercises fiscal control over the provider. For example, if a State health department transfers funds to a State university hospital which is under control of the State board of regents, and the funds could not otherwise be legally transferred to the provider by administrative action, such funds are considered a grant or gift.

Donations of produce or supplies are restricted gifts. The provider may not impute a cost for the value of such donations and include the imputed cost in allowable costs. For example, a provider receives a donation of produce which is valued at \$500. The provider may not include \$500 as a cost of food in its dietary cost center. Instead, the provider makes only a memorandum entry for the donation since the donation of the produce made it unnecessary for the provider to buy the equivalent amount of produce. This donation automatically reduces the provider's food costs by \$500.

If an imputed cost for the value of the donation has been included in the provider's costs, the amount included is deleted in determining allowable costs.

A provider may receive a donation of the use of space owned by another organization. In such case, the provider may not impute a cost for the value of the use of the space and include the imputed cost in allowable costs. If an imputed cost for the value of the donation has been included in the provider's costs, the amount included is deleted in determining allowable costs.

However, if the provider and the donor organization are both part of a larger organizational entity, such as units of a State or county government, the costs related to the donated space are includable in the allowable costs of the provider. For example, if a county home health agency is given space to use in the county office building, costs related to that space may be included in the agency's costs. Such related costs would include, for example, depreciation, costs of janitorial services, maintenance and repairs.

Public Health Service grants are authorized under the Public Health Service Act on a fiscal year basis. In general, the purpose for which the grant was authorized will determine if any of the funds received are applied as a reduction of allowable costs. If, for example, the grant was authorized to be used as the provider deems proper and necessary, the grant would be considered unrestricted and would not be used to reduce allowable costs. However, if the grant was authorized for paying certain costs or groups of costs, the grant would be considered restricted and would be deducted from the costs of services for which the grant was made.

Grants designated to cover only the costs of services provided to patients not covered under Medicare will not be deducted from operating costs in computing allowable costs. However, if the terms of the grant do not specifically exclude the costs of services to Medicare beneficiaries, such costs are deemed to be covered under the grant and the grant would be deducted from operating costs in computing allowable costs.

The intent of this principle is to avoid duplication of recovery by the provider for costs incurred from the Medicare program and from other sources, such as Public Health service grants.

An exception to this general rule is provided where "seed grants" are involved. Grants designated for the development of new health care agencies or for expansion of services of established agencies are generally referred to as "seed money" grants. "Seed money" grants are not deducted from costs in computing allowable costs. These grants are usually made to cover specific operating costs or groups of costs for services for a stated period of time. During this time, the provider is expected to develop sufficient patient caseloads to enable continued self-sustaining operation with funds received from Medicare reimbursement as well as from funds received from other patients or other third-party payers.

Some providers receive financial support through grants or contributions from United Fund or Community Fund monies. Where such contributions are made for the general use of the provider without restriction by the donor, the provider's costs are not reduced by the amount of the contributions. Contributions of funds for operating deficits are in this category and would not serve to reduce the provider's allowable costs.

However, where the donor designates a special cost or category of costs, for which the contribution must be used and, in effect, assumes these costs, the designated cost or group of costs is reduced. For example, if a donor designated his or her contribution to be used for "cancer," the costs related to cancer treatment must be reduced by the amount of the contribution.

CHAPTER 15

COMPENSATION OF OWNERS

COMPENSATION OF OWNERS

A reasonable salary for services of owners is an allowable cost provided the services are actually performed in a necessary function. The amount allowed for services of owners is the reasonable value of the services rendered. As a matter of fact, the test of a reasonable value of the services rendered applies to the compensation of all individuals performing services in connection with the operations of a provider.

The requirement that the function be necessary means that had the owner not rendered the services, the institution would have had to employ another person to perform them. The services must be pertinent to the operation and sound conduct of the institution.

Reasonableness requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable institutions depending upon the facts and circumstances of each case.

Since the compensation allowance for sole proprietors and partners is dependent upon the value of the necessary services rendered, no allowance is granted where such services are not actually rendered. This is true even if an owner is receiving payments from the provider. Therefore, although a partnership agreement might provide for retired partners to continue to receive a share of the partnership profits even though they are not rendering any services, such payments are not considered allowable costs under the program.

With regard to the compensation for services of sole proprietors and partners, the amount determined to be the reasonable value of the services rendered has nothing to do with whether there is any actual distribution of the profits of the business. A distribution of the profits to the proprietor or partners has no effect on allowable cost and is not reimbursable.

For purposes of determining whether the total compensation paid to an owner is reasonable, compensation means any payment regardless of the form in which it is paid. Such payments include:

1. Salary paid for managerial, administrative, professional, and other services;
2. Amounts paid by the institution for the personal benefit of the owner;
3. The costs of assets and services which the owner receives from the institution;
4. Deferred compensation.

There may be instances in which an owner is receiving compensation in a form that without close scrutiny might not be recognized as compensation. Examples of such compensation to an owner include:

1. Supplies and services used for the personal use of the owner;

2. Special merchandise ordered from wholesalers for the owner's personal use;
3. Wages of a domestic or other employee who works in the home of the owner;
4. Personal use of a car owned by the business; and
5. Personal insurance premiums paid for the owner, etc.

Any of the above payments must be included in the owner's total compensation to determine its reasonableness.

Services rendered in connection with patient care include both direct and indirect services in the provision and supervision of patient care, such as administration, management, and supervision of the overall institution.

Services which are not related to either direct or indirect patient care, e.g., those primarily for the purpose of managing or improving the owner's financial investment, are not recognized as an allowable cost.

Compensation of a physician-owner of a facility is subject to an allocation between professional and provider components. (See Section 2108ff in the Provider Reimbursement Manual for details.)

Compensation paid to an employee who is an immediate relative of the owner of the facility is also subject to special review under the test of reasonableness. For this purpose, the following persons are considered "immediate relatives":

1. Husband and wife;
2. Natural parent, child and sibling;
3. Adopted child and adoptive parent;
4. Stepparent, stepchild, stepbrother and stepsister;
5. Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law;
6. Grandparent and grandchild.

No cost may be imputed for the value of services furnished by an immediate relative.

In general, the determination as to the reasonableness of a person's compensation is made by comparing it with the compensation paid to other individuals in similar circumstances. In order to obtain uniformity in the comparisons, HCFA has requested intermediaries to make surveys about every three years of the compensation paid to individual other than owners by comparable institutions in the same geographical areas. The intermediaries submit the data to the appropriate HCFA regional office where it is consolidated with data obtained by other intermediaries and used to produce ranges of reasonable

compensation in the same area. An updating factor is computed and used for each year between surveys. The intermediary applies a set of criteria based on the qualifications and responsibilities of the owner to determine his placement in the range.

In establishing the ranges, the regional offices identify the general pattern of compensation paid for certain types of positions by various categories of providers. The regional offices exclude any extremes, both high and low, from the compensation distribution used in establishing the range. For example, abnormally low amounts of compensation sometimes received by employees of religiously sponsored providers are ignored since circumstances led to the establishment of their rate of pay which are not applicable to other persons.

An updating factor, based on estimated changes in the cost of living, is computed and used for each year between surveys to reflect changing economic conditions. (See Section 904 in the Provider Reimbursement Manual and Section 2120 in the Part A Intermediary Manual for specific updating factors and for examples.)

Although intermediaries are guided by the established ranges in evaluating the reasonableness of an owner's compensation, there may be special circumstances where an intermediary, on the basis of its judgment, allows an amount that is outside the established range. This might occur where the provider has certain characteristics or the owner has special qualifications and experience which would make a comparison with other institutions and individuals unrealistic.

The factors that are considered in determining the reasonableness of an owner's compensation within the range established for a class of institution include the following:

1. The qualifications of the owner including his educational attainment and experience in similar responsible positions. Education and experience are pertinent only as they relate to the job being performed and the services being rendered.

Where an owner-administrator is also a physician, the administrative services performed are evaluated rather than the actual practice of medicine. The compensation allowed is based on the compensation nonphysician administrators receive rather than on the rate physicians receive for their professional services.

2. The number of types of professional and other personnel supervised by the owner.
3. The duties and responsibilities of the owner and the actual services rendered.
 - A. Information as to the owner's actual duties, responsibilities, hours, and days regularly worked, etc. Compensation for "full-time" service requires that at least 40 hours per week be

devoted to the duties of the position for which compensation is requested. Owners devoting less than 40 hours per week to the position will be compensated on a proportionate basis, with 40 hours per week considered to be the full-time basis for such proportionate compensation.

- B. The fact that an owner may have potential supervisory and managerial authority and responsibility for an institution is not as important as the manner in which this authority and responsibility is actually exercised. For example, another individual, perhaps with the designation of assistant administrator, or an outside management consultant, might perform most day-to-day managerial and supervisory functions in an institution. In such case, the right of the owner-administrator to overrule decisions does not constitute a basis for recognition of compensation comparable to administrators in other similar institutions.
4. Where the owner performs services for any other institution or is engaged in any other occupation:
- A. Presumably, where an owner performs services for several institutions, he spends less than full time (i.e., at least 40 hours a week) with each institution. In such cases, allowable compensation should reflect an amount proportionate to a full-time basis. The share of the total compensation for each facility is determined by the percentage of time spent in rendering services in each facility.
 - B. If an owner is engaged in another activity, such as an owner-administrator who also has a private medical practice, he or she ordinarily could not render full-time services as administrator of the institution.

Where an owner indicates he or she functions in an executive role other than as administrator (e.g., president, executive director, etc.) the intermediary will need to ascertain the owner's actual duties and categorize the position by the nature of the services rendered in connection with patient care rather than by the various titles administrators might have.

Where a proprietary provider first enters the program, the owner's compensation is evaluated by its intermediary in terms of the ranges of compensation established for comparable institutions.

The compensation of stockholder-employees is included for a cost reporting period if earned within the period even if not paid until after the close of the period. However, the actual payment must be made (whether by cash, negotiable instrument, or in kind) within 75 days after the close of the period. If payment is not made within the cost reporting period or within 75 days thereafter, the unpaid compensation is not includable in allowable costs either in the period earned or in the period when actually paid.

For this purpose, an instrument to be negotiable must be in writing and signed, must contain an unconditional promise or order to pay a certain sum of money on demand or at a fixed and determinable future time and must be payable to order or to bearer.

There are also a number of factors involved in the determination of the comparability of institutions:

1. The size of institutions is generally measured by the number of beds; however, because of differences in occupancy rates, in some situations the number of patient days for the period in question may also be used in determining whether particular providers are comparable in size.

Where only a portion of the total beds of an institution are certified, the provider should be classified by the total beds available since the compensation paid administrators is based on services rendered to the entire facility. Only a portion of the allowed compensation would be allocated to the certified part of the institution.

For home health agencies, size is measured by the number of visits.

2. Institutions are classified by the type and range of services offered, i.e., medical, surgical, rehabilitative, etc. The range of the services means the extent to which the particular kind of service can be rendered. For example, for rehabilitative services, the range of services refers to the amount and kind of physical therapy available, whether speech therapy is available, etc. In considering the type and range of services rendered, emphasis is given to those services available in the institution rather than services which are available only when arranged for with other organizations by the provider.
3. The number of personnel employed in the various professional and nonprofessional categories is a factor to be considered.
4. In determining the comparability of facilities, geographical location is a consideration. Since consideration is given to the area of the United States in which the institution is located and whether it is in an urban, suburban, or rural setting, differences in prevailing living and wage costs are recognized.

CHAPTER 16

INSURANCE AGAINST LOSSES

Types of Insurance Coverage

Provider Costs for Malpractice and Comprehensive General Liability Protection

Captive Insurance Companies

INSURANCE AGAINST LOSSES

A provider participating in the Medicare program is expected to follow sound and prudent management practices, including the maintenance of an adequate insurance program to protect itself against likely losses, particularly losses so great that the provider's financial stability would be threatened. If a provider chooses not to maintain adequate insurance protection against such losses, the provider cannot expect the Medicare program to indemnify it for its failure to do so. Where a provider chooses not to file a claim for losses covered by insurance, the costs incurred by the provider as a result of such losses may not be included in allowable costs.

If a provider is unable to obtain a particular type of insurance coverage, and it sustains losses at a time of noninsured status, the cost of such losses will be allowable where the provider submits satisfactory evidence to the intermediary to establish the unavailability of the insurance coverage.

If a provider is unable to obtain malpractice insurance coverage, the provider must select one of the self-insurance alternatives in Section 2162 Provider Reimbursement Manual (PRM) to protect itself against such risks. If one of these alternatives is not selected and the provider incurs losses, the costs of such losses and related expenses are not allowable.

INSURANCE COSTS

The reasonable costs of insurance purchased from a commercial carrier are allowable if the type, extent, and cost of coverage are consistent with sound management practice. Reimbursement of insurance premiums is limited to the total amount of insurance coverage in the policy. For example, there have been a few instances when the premium for an insurance policy covering a total amount of \$300,000 for malpractice insurance cost \$350,000. Under such conditions, Medicare will recognize only \$300,000 as the allowable cost.

Provider's contributions to a self-insurance fund are not allowable costs under Medicare. Medicare will, however, reimburse a provider which maintains a self-insurance fund for actual losses incurred, under the following conditions:

1. In the event of a loss, the amount allowable is limited to no more than the balance in the reserve fund at the date of the loss.
2. The provider must furnish to the intermediary pertinent details about the specific assets that are to be covered by the self-insurance reserve fund.
3. The reserve must be maintained in a segregated account and the funds must not be commingled with any other funds.
4. The self-insurance reserve must be sufficient to meet losses of the type and to the extent that they would ordinarily be covered by insurance.

5. Contributions to the reserve must be made not less frequently than annually.
6. The provider's total allowable interest expense under the Medicare program must be offset by income earned by invested insurance reserve funds.
7. Where appropriate, the provider must demonstrate the ability to have or to employ an inspection service, a loss-handling service, and a legal defense service similar to those used by insurance companies.

However, see the discussion of malpractice insurance coverage later in this chapter for a special exception to the rule of nonallowability for contributions to self-insurance funds.

Generally, the following types of insurance are recognized:

1. Property Damage and Destruction — This type of insurance covers losses due to the damage to, or the destruction of, the provider's physical property. Coverage is available to insure against losses resulting from fire or lightning, windstorm, earthquake, sprinkler leakage, water damage, automobile damage, etc.
2. Liability — This insurance includes professional liability (malpractice, error in rendering treatment, etc.), unemployment compensation, workers' compensation, automobile liability, etc.
3. Consequential Loss or Indirect Loss — There are various indirect losses a provider may incur in connection with property damage or other occurrences which interrupt the normal operation of the institution. The cost of business interruption or other similar insurance is allowable; however, the premium cost for "guaranteeing profits" is not allowable.
4. Theft Insurance — This generally includes fidelity bonds and burglary insurance.

Certain types of insurance policies are subject to a customary deductible. To purchase these policies without the deductible feature would result in a substantially higher premium and thus would not be in keeping with sound business practice. Therefore, losses incurred attributable to the customary deductible clause are considered allowable costs under the Medicare program. (See Section 2162.5 in the Provider Reimbursement Manual (PRM) for special rules for malpractice insurance.)

Where a provider has purchased insurance without the customary deductible feature and, as a result, is charged a substantially higher premium, the amount of the insurance premium which exceeds the insurance premium with the customary deductible clause is not an allowable cost.

Liability damages paid by the provider, either imposed by law or assumed by contract, which should reasonably have been covered by liability insurance, are not allowable. Examples of such payments to others would include automobile liability insurance; professional liability (malpractice, negligence, etc.); owners, landlords and tenants liability, and worker's compensation.

Any settlement negotiated by the provider or award resulting from a court or jury decision of damages required to be paid by the provider, which are in excess of the limits of the provider's policy are allowable costs. The reasonable cost of any legal fees connected with the settlement or award is also includable in allowable costs. The provider is required to submit evidence to the satisfaction of the intermediary that the insurance coverage at the time of the loss reflected the decisions of prudent management.

Damages awarded by a court or amounts paid to an injured party for an out-of-court settlement for an event that occurred prior to the provider's participation in the Medicare program are not includable in allowable costs. This is true even though the determination or actual payment of the damages is made subsequent to the provider's entry into the program.

Protection against theft losses is generally covered by two types of insurance -- fidelity bonds and burglary insurance. Fidelity bonds provide protection against losses resulting from all types of theft by employees and corporate officers. Burglary insurance protects against losses resulting from thefts not involving employees. The costs of both types of theft insurance are allowable costs.

Where a provider exercises prudent management by purchasing adequate theft insurance, theft losses over and above the coverage limits of the insurance would be includable in allowable costs subject to the following conditions:

1. The provider must purchase an adequate amount of theft insurance based on the amount of coverage recommended by insurance companies and based on the provider's theft loss experience, if any. The premium must be at a competitive rate;
2. The provider must maintain adequate internal controls against theft. These would include, but are not limited to, the use of appropriate accounting controls and the maintenance of appropriate physical security measures e.g., guards, locks, employee badges, etc.;
3. The provider must document the theft loss by including evidence such as, but not limited to, insurance company reports and police reports. This policy is effective with losses incurred in cost reporting periods beginning after December 31, 1977.

In the ordinary course of operations, a provider may incur a number of losses of minor equipment or supplies which are generally not covered by insurance because of their low cost or the frequency of the occurrences of loss. This includes such losses as the disappearance of linen, supplies, food and silverware, the breakage of equipment, and the spoilage of drugs and food. Where such losses are generally not insured, the program will recognize them as allowable costs to the extent that the provider can establish proof of loss.

Casualty Losses — For Medicare reimbursement purposes, a casualty is defined as the complete or partial destruction of property resulting from an identifiable event of a sudden, unexpected or unusual nature. Casualty losses include, but are not limited to, damage from a hurricane, tornado, storm, fire, flood, accident, earthquake, and vandalism.

A provider is expected to protect its depreciable assets against casualty losses through its insurance program. As stated in the following sections, actual losses sustained by a provider which are not compensated by insurance proceeds received, generally are not included in allowable costs where the lack of insurance coverage reflects imprudent management.

Where allowable casualty losses incurred in any cost reporting period do not exceed \$5,000, the entire amount is included in allowable cost in the year of the casualty.

Where the amount of the allowable losses in any cost reporting period exceeds \$5,000, the total amount of the loss is recognized as a deferred charge and treated as indicated in the following sections.

Actual costs incurred in the restoration of any asset (including any expenditures from a self-insurance reserve fund), are added to the adjusted cost basis of the asset. The total revised cost is capitalized over what is determined to be the remaining useful life of the asset.

If an asset, on which depreciation was previously allowed, is entirely destroyed by fire or other casualty, and the amount of the casualty loss is considered an allowable cost, the undepreciated cost or the unrecovered book value of the asset completely destroyed is recognized as a deferred charge. The undepreciated cost must be reduced by any amounts received from insurance and from local, State, Federal grants or other sources. The deferred charge is amortized over the estimated useful life of the asset which replaced the completely destroyed asset.

Where a depreciable asset is partially destroyed or damaged as a result of fire or other casualty, a reduction in its cost basis (the book value) is assumed to have taken place. Therefore, the cost basis of the asset must be reduced to reflect the amount of the casualty loss, regardless of whether the loss is covered by insurance.

The amount of the casualty loss is the difference between the fair market value immediately before the casualty and the fair market value immediately after the casualty. However, for program purposes the amount of the loss to be recognized is limited to the percent of loss in fair market value applied to the net book value of the asset at the time the casualty occurred. This method of calculating the loss recognizes the actual reduction in the cost value of the asset rather than recognizing the reduction in replacement value. (See following example.)

The fair market value generally can be ascertained by competent appraisal. If no appraisal is made, the cost of repairs to the damaged property is acceptable as evidence of the loss of value if the repairs restore the property to its condition immediately before the casualty, and as a result of the repairs, the value of the property has not been increased.

The amount of the casualty loss is then deducted from the cost basis of the asset before the casualty to arrive at the adjusted cost basis of the asset. Any insurance proceeds received or recoverable must be deducted from the amount of the casualty loss to determine the gain or the loss.

EXAMPLE:

Fair market value - before	\$ 16,000
Fair market value - after	<u>4,000</u>
Loss	<u>\$ 12,000</u>

Percentage of loss in fair market value ($\$12,000 - \$16,000 = 75\%$)

Amount of loss to be recognized by the program:

Net book value of the asset at the time of the casualty	\$ 10,000
Amount of partial casualty loss to be allowed ($75\% \times \$10,000$)	<u>7,500</u>
Adjusted cost basis of asset	<u>2,500</u>

The allowable portion of the partial casualty loss (\$7,500) is recognized as a deferred charge and amortized over the estimated useful life of the restored asset.

If the asset is no longer used in providing patient care or is not replaced, no amount of the loss is includable in allowable costs. If, after the fire or other casualty, an asset is disposed of by scrapping, income received from salvage is treated as a reduction in the amount of the loss. Conversely, where additional expense is incurred in the scrapping operation, such cost is added to the loss.

Where the provider maintains a self-insurance reserve fund, the amount of the casualty loss recognized as an allowable cost is limited to the lesser of the decrease in fair market value, as adjusted, of the damaged or destroyed asset or the amount of cash, investments, etc., comprising the accumulated balance in the self-insurance reserve account.

EXAMPLE:

Amount accumulated in the self-insurance reserve fund	<u>\$ 20,000</u>
Cost of Asset	\$100,000
Less: Depreciation Allowed	<u>60,000</u>
Unrecovered book value	\$ 40,000
Less: <u>Amount of Casualty Loss (as adjusted)</u>	<u>25,000</u>
Adjusted cost basis of asset	<u>\$ 15,000</u>

As the allowable loss is limited to the lesser of the amount of the casualty loss, as adjusted, or the total amount in the self-insurance reserve fund, the allowable loss is limited to \$20,000. This amount is entered on the books of the provider as a deferred charge and amortized over the estimated useful life of the restored or replacement asset. The balance of the loss, \$5,000, is not recognized as an allowable cost because the provider failed to maintain an adequate reserve in the self-insurance reserve fund.

If the provider sells its assets while participating in the Medicare program or within one year after termination from the program, the balance in the deferred charge account attributable to the destroyed asset is not includable in determining gain or loss on the disposal of depreciable assets. It does not matter whether the termination is voluntary or involuntary.

However, if the sale of assets is made to a related organization and the purchasing organization continues as a provider in the program, the unrecovered deferred charge will continue to be amortized over the remaining estimated useful life of the replacement or restored asset. Where the assets are sold to an unrelated provider organization, amortization of the remaining deferred charge by the purchaser will be allowed.

Losses which are not considered casualty losses, such as reductions in the value of property resulting from a nearby disaster, etc., are not included in allowable costs.

EXAMPLE: A public bridge which provided the most direct access to the provider facility, was completely destroyed by flood. The bridge was not replaced because of the high cost of reconstruction in view of its limited utility. The only other access to the facility involved a lengthy and more circuitous route through undesirable areas. This inconvenience of access resulted in a reduction in the economic value of the property, a loss which is not includable in allowable costs.

A special type of deductible clause is written for earthquake insurance, with the deductible being stated in terms of a percentage of the value of the property rather than in a dollar amount. In certain States, the form of the deductible clause contains a mandatory minimum deductible of 5 percent of the insured value of the property, and, for some buildings, the clause may require a deductible as high as 15 percent. In these cases, even though the deductible is not a nominal amount, the deductible clause is considered standard coverage in the particular area, and losses resulting from the application of this deductible clause are included in allowable costs.

The coinsurance feature of insurance policies was developed to encourage the insuring of a high percentage of property value by offering a reduced rate to the insured. The coinsurance clause stipulates that the insured maintain insurance equal to an agreed percentage (usually 80 percent or more) of the replacement cost of the asset, regardless of the undepreciated cost basis (book value) of the asset.

If the insured (the provider) fails to maintain insurance at the agreed fixed percentage of the replacement cost of the property, the provider then becomes a coinsurer with the insurance company and, in the event of the loss, shall, to the extent of the deficit, bear its proportion of the loss.

Losses resulting from the application of the coinsurance clause are not allowable costs to the extent that the provider has failed to maintain insurance at the agreed fixed percentage of the value of the property to be considered fully insured.

EXAMPLE: A provider insures a piece of equipment for \$3,000, but its replacement cost is \$5,000. The policy contains an 80 percent coinsurance feature. If the property sustains \$1,000 worth of damage, the provider receives only \$750 from the insurance company, computed as follows:

$$\begin{array}{rcl} \text{amount of insurance} & (\$3,000) & \\ \hline \text{amount of insurance} & (4,000) & \\ \text{required to meet 80} & & \\ \text{percent requirement} & & \\ \text{(80\% of \$5,000)} & & \end{array} \quad \times (\$1,000) = \text{settlement } (\$750)$$

The provider sustains a \$250 loss which is not allowable since it is due to the fact that the provider has underinsured its property. If the provider had maintained \$4,000 insurance on the asset (80 percent of the replacement cost), the settlement would have been \$1,000.

A loss which is in excess of the amount of insurance carried by the provider is considered to result from underinsurance and is not reimbursed by the program.

For example, if a provider insures an asset having a replacement cost of \$12,000 for \$8,000 and the asset is completely destroyed by fire, the provider receives \$8,000 from the insurance company. Where the undepreciated cost basis is \$10,000, the provider incurs a loss of \$2,000. The loss of \$2,000 cannot be claimed as an allowable cost since it results from the asset being underinsured.

Where a provider receives insurance proceeds in excess of the undepreciated cost basis of the asset, the provider has a gain, which is treated in accordance with instructions contained in Section 132, PRM. If the insurance proceeds exceed the undepreciated cost basis of the asset, the gain reduces the amount of allowable depreciation allowed for the asset under the program.

Extraordinary Casualty Losses -- As you learned at the beginning of this chapter, sound and prudent management practices include purchasing adequate insurance to provide protection against losses from the usual casualties and losses which would threaten the institution's financial stability. However, coverage against every possible type of loss would not be prudent or feasible. Thus, a provider may have an insurance program which would be considered adequate to insure against those risks that the institution could not afford to assume and yet sustain an uninsured loss from an unexpected quarter. This can occur because the failure to purchase insurance coverage for a highly improbable type of loss, e.g., earthquake insurance in an area where earthquakes seldom occur, would not be considered imprudent management.

Where such casualties occur, the amount of the casualty loss less the amounts that were received from insurance and from local, State, Federal grants or other sources, if any, will be recognized as a deferred charge to be amortized over the expected subsequent useful life of the restored or replaced asset.

If the provider decides not to use the damaged asset any longer in patient care service or to replace it, no amount of the loss is includable in allowable costs.

Where an asset is entirely destroyed by fire or other casualty to the point of being unrepairable, the loss is generally considered an allowable cost for Medicare reimbursement purposes only where the loss is related to the deductible factor of the insurance policy or the loss is such that the risk would not ordinarily be insured in adequate insurance programs.

Where an asset is partially destroyed or damaged as a result of fire or other casualty, the loss, as in the case of the total casualty loss, is generally considered an allowable cost for Medicare reimbursement purposes only where the loss relates to the deductible factor of the insurance policy or the loss is such that it is not ordinarily insured against an adequate insurance program. (See Section 133.3 PRM for the procedure to follow in adjusting the cost basis of the depreciable asset to reflect the amount of the casualty loss, even though the loss is not an allowable cost for purposes of Medicare reimbursement.)

PROVIDER COSTS FOR MALPRACTICE AND COMPREHENSIVE GENERAL LIABILITY PROTECTION

BACKGROUND

As a background for Medicare's special rules for malpractice insurance, you need to know that there was a period from 1974 on when some providers were unable to purchase any malpractice insurance from a commercial insurance company; other providers were quoted premiums of \$1,300,000 for malpractice coverage of \$1,000,000; and premiums on some policies increased from \$48,000 in 1974 to \$173,000 in 1975 for the same amount of coverage.

In view of the malpractice insurance crisis, Medicare reviewed its reimbursement policy to determine what help, if any, it could give providers. After considering many alternatives, the Medicare Bureau came to the conclusion that one possible solution was to give providers a special exception and reimburse them for contributions to a self-insurance fund for malpractice coverage, subject to certain restrictions. As you know, Medicare does not reimburse providers for contributions to self-insurance funds because such contributions are not actual incurred costs, they are merely estimates of contingent liabilities which may, or may not, occur in the future.

As a result of the exception, providers had the following alternatives:

1. Purchase insurance from a commercial insurance company,
2. Purchase insurance from a limited purpose insurance company (captive insurance company, see below),
3. Provide total self-insurance, or
4. Provide a combination of purchased insurance and self-insurance.

(NOTE: It is important to remember that we are dealing with malpractice insurance for provider activities, not for private physicians practicing in the hospital. The cost of malpractice coverage that a provider incurs for its employee interns and residents is allowable. However, the cost of malpractice coverage incurred by a provider for the personal risks of physicians other than interns and residents for direct medical care rendered to patients is not allowable except where the provider incurs such cost for its hospital-based physicians. This cost incurred by the provider for its hospital-based physicians must be considered part of the physicians' total compensation.)

Most of the changes in policy for reimbursement of malpractice insurance have been incorporated in Section 2162 in the Provider Reimbursement Manual (PRM). Some of the highlights of these changes are as follows:

The provider is expected to select the most reasonable and prudent arrangement, taking into account all pertinent facts and circumstances related to its organization and operation.

If the provider makes a change from a commercial insurance policy to self-insurance, the provider must prepare for the intermediary's review a statement which shows that the change results in a reasonable cost for the coverage offered and that the extent of coverage is consistent with sound management practice.

Payments into a self-insurance fiduciary fund are allowable costs if the provider (or pool) sets up a program which meets the conditions in Section 2162.7 PRM (see below). This is applicable to providers who decide to self-insure some of the risk independently (or as part of a group or pool) and purchase commercial insurance for the remainder of the risk. It is also applicable to providers which decide to fund all of the risk through self-insurance.

REQUIREMENTS UNDER SECTION 2162.7 PRM

Under either of those conditions, payment into such funds are allowable costs, if these self-insurance funds meet the conditions in Section 2162.7 PRM, which are as follows:

1. The provider or pool establishes a fund with a recognized independent fiduciary such as a bank or trust company. The provider or pool must enter into a written agreement which includes all of the following elements:
 - A. The fiduciary agreement must include the appropriate legal responsibilities and obligations required by State laws.
 - B. The fiduciary must have legal title to the fund and be responsible for proper administration and control. The fiduciary cannot be related to the provider either through ownership or control. (This means that the home office of a chain organization or a religious order of which the provider is an affiliate cannot be the fiduciary.) Investments which may be made by the fiduciary from the fund are limited to those approved under State law governing the use of such fund.

Loans by the fiduciary from the fund to the provider or persons related to the provider are not permitted.

- C. The fiduciary agreement must provide that withdrawals from the fund must be only for malpractice and comprehensive general liability losses and related expenses.

Any rebates, dividends, etc., to the provider from the fund will be used to reduce allowable cost.

- D. The agreement must state that upon termination from the Medicare program, the provider must obtain a determination of

the adequacy of the fund balance as of the date of termination from an independent actuary, insurance company or broker. If the reserve fund is deemed excessive, the excess amount must be offset against the provider's allowable costs in its final cost report. If the reserve fund is deemed inadequate, additional contributions to the fund, subsequent to the date of termination, are not allowable.

- E. The agreement must require that a financial statement be forwarded to the provider or pool members by the fiduciary no later than 60 days after the end of each annual insurance reporting period.

This statement must show the balance in the fund at the beginning of the period, contributions during the period, the amount and nature of final payments, including a separate accounting for claims management, legal expenses, claims paid, etc., and the fund balance at the end of the period.

- F. The agreement must provide that any income earned by the fund must become part of the fund and used in establishing adequate fund levels.

- 2. The provider must submit to the intermediary an annual certified statement from an independent actuary, insurance company or broker. The actuary, insurance company or broker shall determine the amount necessary to be paid into the fund. The fund should provide for reserves for losses based on accepted actuarial techniques customarily employed by the casualty insurance industry. The fund should also include expenses related to the self-insurance fund.

The actuary, insurance company, or broker must state the actuarial basis and the coverage period used in establishing reserve levels. Reserves will not be recognized as allowable Medicare costs for losses specifically denied by other subsections of Sections 2160, 2161, and 2162 in the PRM. For example, reserve payments will not be recognized for items such as:

- A. Losses in excess of the greater of 10 percent of a provider's net worth or \$100,000 where a provider elects to pay losses directly in lieu of establishing a funded self-insurance fund (Section 2162.5 PRM).
 - B. Losses in excess of coverage levels which an intermediary deems do not reflect the decisions of prudent management (Section 2162.6 PRM).
 - C. Losses in excess of coverage for events that occurred prior to a provider's participation in the Medicare program (Section 2162.6 PRM).
- 3. A provider or a pool must have an ongoing claims process and risk management program. The provider or pool may either use its own qualified staff, or an independent contractor, such as an insurance company to adjust claims. In addition, a provider or pool must obtain adequate legal assistance in carrying out its claims process.

Each provider must also have an adequate risk management program to examine the cause of losses and to take action to reduce the frequency and severity of losses. Such a risk management program must have the essential characteristics of programs required by insurance companies which currently insure providers for these risks. This means a provider must have an ongoing safety program, professional and employee training programs, etc., to minimize the frequency and severity of malpractice and comprehensive general liability incidents.

Expenses related to losses paid out of a self-insurance fund are allowable, as for example:

Expenses of establishing the provider fund or pool

Expenses for administering the claims management program

Expenses involved with the maintenance of the fund by the fiduciary

Legal expenses

Actuarial expenses

Purchase of excess insurance coverage by the fiduciary or pool

Risk management

All other expenses should be included in the provider's administrative and general costs in the year incurred, provided such expenses are reasonable and proper. (See Note at end of this chapter regarding changes in this requirement effective for cost reporting periods beginning on or after July 1, 1979.)

DEDUCTIBLES

Where a provider is willing to commit its own resources toward meeting first dollar losses through a deductible, losses related to the deductible are allowable costs in the year paid -- without funding -- if the aggregate deductible is not more than the greater of:

Ten percent of the provider's net worth at the beginning of the insurance period, or \$100,000. (For chains, 10 percent of the chain organization's net worth or \$100,000 per provider.)

The same rule applies where a provider coinsures with an insurance company.

(This requirement is deemed a reasonable test as to whether the provider is acting prudently in deciding to meet first dollar losses or coinsurance payments out of available resources. It also permits a provider to pay reasonable losses without incurring costs to fund such payments.)

If the provider's deductible or coinsurance exceeds the above requirements and the provider does not make payments into a fiduciary fund as required by

Section 2162.7 PRM, any losses paid by the provider in excess of the greater of 10 percent of the provider's or, if applicable, a chain organization's net worth, or \$100,000 per provider, are not allowable.

For purposes of this section, a "deductible" refers to the amount of first dollar losses not covered by a purchased insurance policy, a funded self-insurance program, or a combination of both.

Where a provider purchases insurance from a commercial insurance company and incurs losses which are in excess of specified deductible or coinsurance provisions, such costs are allowable in the year paid where the provider submits evidence to the satisfaction of the intermediary that the insurance coverage reflected prudent management. The same rule applies to insurance purchased from captive insurance companies or to actuarially determined funded contributions to an approved self-insurance fund. (See following section for description of captive insurance companies.)

LIMITED PURPOSE INSURANCE COMPANIES (CAPTIVE INSURANCE COMPANIES)

Some providers, groups of providers, and State hospital associations have established limited purpose insurance companies -- otherwise referred to as captive insurance companies -- to insure themselves against malpractice losses.

The regular premiums paid to such companies are allowable costs if they are not in excess of available comparable commercial insurance premiums. If comparable commercial insurance premiums are not available, the captive insurance company must obtain an evaluation of the reasonableness of its insurance premium from an independent actuary, insurance company or broker. Reimbursement is limited to this determination.

Supplemental premiums which are assessed by the limited purpose insurance companies to build reserves against contemplated losses (as distinguished from capital costs) are allowable costs if, when added to the regular premium, the total premium costs do not exceed a commercial insurance premium for comparable coverage.

Any excess premiums may be allowed in a subsequent cost reporting period to the extent that, when added to the premiums paid in that period to the captive insurance company, the total premiums do not exceed the comparable commercial insurance premiums for that period.

These reserve premiums must have the essential characteristics of normal insurance premiums, i.e., they must stand at risk against potential losses and must be available to support losses.

If the insurer returns any funds to the provider, they must be offset against allowable costs in the year the provider receives them.

Insurance premiums paid to a related captive insurance company are limited to the same requirements as for self-insurance, meaning that premiums are limited to actuarially determined loss reserves and related expenses. The reserves, of course, must be in the hands of an independent fiduciary.

The initial capital or any subsequent capital payments made by providers to establish or maintain limited purpose insurance companies are not reimbursable under Medicare. Such capital payments include the purchase of stock or surplus certificates (mutual insurance companies) or other payments, such as special dues assessment paid to a hospital association which then establishes a limited purpose insurance company.

The captive insurance company must have an adequate claims management and risk management program.

In cases where a limited purpose insurance company (captive insurance company) has both Medicare and non-Medicare participating providers paying premiums, such premiums must be determined so that Medicare providers will not share in premium costs that should be borne by the non-Medicare providers, and non-Medicare providers will not share in premium costs that should be borne by Medicare providers.

If a provider or group of providers is related to the insurer through ownership or control as defined in Chapter 10 PRM, the following additional provisions apply:

1. The captive insurance company must be established in and meet the appropriate insurance laws of one of the United States, District of Columbia, or foreign government, if it is formed offshore.
2. The excess of actuarially-determined loss reserves and related operating expenses over actual losses and related operating expenses and gains and losses from investments must be taken into account in establishing reasonable premium levels. The premiums must not include a profit factor.
3. All rebates and distributions paid by a captive insurance company to providers must be offset against the provider's allowable malpractice costs for cost reporting periods beginning on or after July 1, 1979. (Prior to July 1, 1979, providers offset rebates and distributions against administrative and general expenses in the year received.)

However, if a captive insurance company is liquidated, no offset is required for the return of capitalization costs previously paid by providers receiving the rebate.

If payments are made to other than providers, e.g., the home office of a chain organization, appropriate adjustment of providers' costs is still necessary. Proper allocation of distributions by the home office to the providers must be made, based on the appropriate facts in each situation.

4. If a provider terminates from the Medicare program, the provider must obtain a final determination of the adequacy of premium reserves as of the date of termination. This determination must be obtained from an independent actuary, commercial insurance company or broker. If the reserves are deemed excessive at the date of termination, the excess amount must be offset against the provider's allowable costs in its final cost report. If reserves are deemed inadequate, additional premium payments subsequent to the date of termination are not allowable provider costs.

5. In the case of offshore captives (i.e., not in the United States) investments by a captive insurance company are limited to low-risk investments such as bonds and notes issued by the United States Government, or debt securities issued by United States corporations or governmental entities within the United States rated in the top two classifications by United States-recognized securities-rating organizations. All such captives are required to submit annually to a designated intermediary a certified statement from an independent certified public accountant or actuary attesting to compliance or noncompliance with this requirement for the previous period.

These investments cannot be pledged or used as collateral for loans obtained by the captive or parties related to the captive either directly or indirectly, nor may investments be made in a related organization.

6. Loans or any transfer of funds by the insurance company to policyholders, owners of providers, or parties related to them are prohibited.

OTHER PROVISIONS

Losses in excess of coverage for events that occurred prior to the provider's participation in the Medicare program are not allowable. Medicare's participation in contributions to the fund will be limited to actual payments made by a provider into the fund.

Accruals of payments to be made into the fund are allowable costs in the year of accrual if paid within 75 days after the end of a provider's cost reporting period. Payments made after the 75th day will be deemed allowable in the reporting period paid provided that total contributions made in that period do not exceed the amount prescribed by the actuary as necessary for the adequacy of the fund.

Contributions for any period in excess of the amount required are not allowable costs for such period but may be allowed in the subsequent reporting period to the extent that, when added to the contributions paid in the subsequent year, the sum does not exceed the prescribed amount.

Where a provider has no insurance protection, either in the form of a captive insurance or commercial insurance policy, or a self-insurance fund, any losses and related expenses are not allowable.

There is one exception to this rule. In the case of governmental providers -- Federal, State or local -- Medicare will reimburse its share of actual losses in the year paid, without funding or subject to the deductible provisions, but only if the governmental provider demonstrates to its intermediary that it has a claims management and risk management program.

The provisions of Section 2162 are effective with payments for protection beginning April 1, 1977.

NOTE: Prior to July 1, 1979, malpractice costs were accumulated in the administrative and general cost center and were allocated to other cost centers on the basis of accumulated costs. The final costs in the revenue-producing cost centers, including appropriate overhead costs, were then apportioned to Medicare, using the ratio of Medicare charges to total charges or some other appropriate statistical basis.

An amendment to Regulation Section 405.452, which became effective for cost reporting periods beginning on or after July 1, 1979, changed the basis for apportioning malpractice insurance premiums, self-insurance fund contributions, and allowable malpractice losses. The change resulted from a study by a DHHS consultant which indicated that Medicare was paying a disproportionate amount of malpractice costs. The study showed that malpractice awards for Medicare patients are significantly lower in amount than losses for other patients.

The lower awards for Medicare patients result because the income potential and life expectancy of these patients are less than the non-Medicare population. Thus, the use of overall Medicare utilization to allocate malpractice costs results in Medicare's paying a disproportionate amount of malpractice costs.

This amendment avoids these disproportionate payments by restructuring cost finding and cost apportionment procedure. Costs of malpractice insurance premiums and self-insurance fund contributions are accumulated in a specific malpractice cost center and directly apportioned to Medicare based on the provider's Medicare malpractice loss experience.

The dollar ratio of malpractice losses paid for Medicare beneficiaries to total malpractice losses paid for all patients for the current cost reporting period and the preceding four year period provides the basis for apportioning these malpractice costs to Medicare.

If a provider has no malpractice loss experience for the five year period, the costs of malpractice insurance premiums of self-insurance fund contributions must be apportioned to Medicare based on the national ratio of malpractice awards paid to Medicare beneficiaries to malpractice awards paid to all patients. The Health Care Financing Administration will calculate this ratio periodically based on the most recent departmental closed claim study.

If a provider pays allowable uninsured malpractice losses incurred by Medicare beneficiaries, either through allowable deductible or coinsurance provisions, or as a result of an award in excess of reasonable coverage limits, or as a governmental provider, such losses and related direct costs must be directly assigned to Medicare for reimbursement.

This amended regulation also affects Medicaid (Title XIX) reimbursement. States participating in Medicaid are required to adopt Medicare standards and principles for determining reasonable cost reimbursement for inpatient hospital services. In lieu of adopting Medicare standards and principles, States may provide for payment rates that are no higher than the amounts that would be determined by using Medicare principles of reimbursement.

CHAPTER 17

Deferred Compensation Plans

Pension Plans

Life Insurance Premiums

DEFERRED COMPENSATION

Deferred compensation refers to salary or wages or other compensation which is currently earned by an employee but which is not received until a future period, usually after retirement. Accordingly, a deferred compensation plan defers the employee's receipt of income beyond the year in which it is earned.

Providers may establish deferred compensation plans for their employees but Medicare reimbursement for deferred compensation plans is subject to the rules and restrictions set forth in Section 2140 of the Provider Reimbursement Manual (PRM).

Contributions made by a provider for the benefit of employees under a deferred compensation plan are reimbursable when, and to the extent that, such costs are actually incurred and met by the provider. The requirements of this section are applicable not only to provider costs but also to costs related to deferred compensation plans for hospital-based physicians who furnish direct patient care.

Deferred compensation plans must be funded. Provider payments under unfunded deferred compensation plans are considered as an allowable cost only when actually paid to the participating employee and only to the extent considered reasonable.

The deferred compensation plan must be formal, established and maintained by the provider and communicated to all eligible employees. A formal plan is one that is provided for in a written agreement executed between the provider and the participating employees. It is a permanent plan which

1. prescribes the method for calculating all contributions to the fund established under the plan,
2. is funded in accordance with the provisions described below,
3. provides for the protection of the plan's assets,
4. designates the requirements for vested benefits,
5. provides the basis for the computation of the amount of benefits to be paid, and
6. is expected to continue despite normal fluctuations in the provider's economic experience.

Contributions to the plan may be made by the provider only, or by the provider and the employee. The provider's contribution is established by the terms of the deferred compensation agreement and made for the sole benefit of participating employees.

If the employee contributes to the fund, it is generally a voluntary contribution which is made by the employee in addition to the amount the employer is required to contribute.

For example, an employee receives a salary of \$15,000. The employer (the provider) has established a deferred compensation plan which requires a contribution of \$2,000 for the employee. In addition, the employee voluntarily contributes an additional \$1,000 to the fund. As a result, the employee receives \$12,000 as immediate salary, and \$3,000 is contributed to the deferred compensation fund, \$2,000 by the provider and \$1,000 by the employee. (Of course, the employee's total salary, \$15,000, must be reasonable in relation to the services rendered by the employee to be allowable.)

Funding of Deferred Compensation Plans

A funded plan is one in which contributions are required to be systematically made to a funding agency for the purpose of meeting retirement benefits. For Medicare purposes, a funding agency is either a trustee, an insurance company, or a custodial bank account which provides for the accumulation of assets to be used for the payment of benefits under the deferred compensation plan. Both provider and employee contributions to the deferred compensation plan must be used to purchase an insured plan with a commercial insurance company, or to establish a custodial bank account, or to establish a trust fund administered by a trustee. Regardless of the funding mechanism utilized, all provider and employee contributions to the fund established under the deferred compensation plan and income therefrom must be used for the sole benefit of the participating employees.

1. Commercial Insurance as a Funding Mechanism -- A provider cost for a funded deferred compensation plan is recognized when there is an actual expenditure of funds by the provider to a commercial insurance company for the sole benefit of the participating employees. There are several types of insurance policies which are recognized as a funding medium for deferred compensation plans.
 - A) Retirement Annuity Contract -- A retirement annuity contract (which insurance companies have given various names) is recognized as a funding medium for deferred compensation plans. A retirement annuity contract generally provides for an accumulation of premiums and interest less expenses to a predetermined date, usually the annuitant's retirement age. The amount accumulated is used to purchase a contract in which annuity payments are made to the retired employee or his survivor.
 - B) Retirement Income Policy -- A retirement income policy (which insurance companies have also given various names) is recognized as a funding medium for deferred compensation plans. A retirement income policy usually combines the features of ordinary life and endowment policies. Upon reaching a stipulated age (usually retirement age), the insured will receive a pension for a period of years consisting of periodic payments varying in amount dependent upon the principal sum of insurance. This contract provides, as a secondary feature, a designated amount of insurance protection during the lifetime of the insured.

- C) Deferred Group Annuity Contract -- A deferred group annuity contract is also recognized as a funding medium for deferred compensation plans. Under this plan, a paid-up unit of annual income at normal retirement age is purchased for each employee at the end of each year of employment. The unit purchased is expressed as a percentage of the earnings of the employee in that year. For example, an employee who has worked 30 years for a provider under a one and one-half percent benefit plan would receive an annual pension at retirement of 45 percent (i.e., 30 times one and one-half percent) of his average annual salary.

However, the purchase of an ordinary life insurance contract is not a deferral of compensation and is not recognized as a funding mechanism. Nor is such a contract recognized even though it is convertible at the normal retirement date specified in the policy to an annuity payable over the remaining life of the employee, because this arrangement is essentially a variation of life insurance rather than deferred compensation.

2. Trust Fund as a Funding Mechanism -- When a provider establishes a trust fund for a deferred compensation plan, the trustee(s) should be appointed by the executive board or a committee of the provider to protect the fund's assets and its distribution to the beneficiaries under the plan. The trustee may be either a member of the provider's organization or a third-party trustee.
3. Custodial Bank Account as a Funding Mechanism -- Generally, a custodial bank account results from an administrative and custodial arrangement between a provider and a bank under which the provider transfers deferred compensation amounts to the bank. As custodian of the deferred compensation funds, the bank is responsible for the safekeeping of the funds. A custodial bank account may be an acceptable funding mechanism for deferred compensation plans provided that:
- A) all assets, including any annuity, endowment, and other insurance policies, in the custodial account are registered and held in the name of the custodian until distributed to the participants pursuant to the terms of the deferred compensation agreements, and
- B) the terms of the custodial contract specify that no part of the funds in the custodial account may be used for or diverted to purposes other than for the exclusive benefit of the participating employees or their beneficiaries as required by the deferred compensation agreement.

4. Trustee and Custodial Fees -- Reasonable trustee or custodial fees paid by the provider are allowed as an administrative cost. However, the cost of such fees will not be allowed to the provider where the deferred compensation plan provides that they will be paid out of the corpus or earnings of the fund because the provider has incurred no additional cost from its own funds.

Plan's Transactions

1. Transactions -- All transactions involving the deferred compensation fund must be made under conditions comparable to arm's length transactions. The provider cannot transfer, either by sale or exchange, its securities and other property to the deferred compensation fund at more than adequate consideration. Likewise, a deferred compensation fund cannot sell its assets either to a provider or a third party at less than adequate consideration. All assets accumulated by the plan must be distributed exclusively to the participating employees or their beneficiaries.
2. Earnings -- The plan must specify that the interest, capital gains and losses, and dividends earned from the investment of the fund's assets will be added to or deducted, as applicable, from the corpus of the deferred compensation fund. Actuarial gains and losses should be utilized in a rational and consistent manner to adjust a provider's cost for a deferred compensation plan. (Actuarial gains and losses are adjustments needed to reflect actual experience. They are also used to revise the actuarial assumptions to be used in the future.)
3. Loans Made from the Deferred Compensation Fund -- The deferred compensation fund may make a loan out of either corpus or income to a provider on the condition that the fund receive adequate security and a reasonable rate of interest on the loan. Adequate security means something of value in addition to, and supporting, a promise to pay, which is so pledged to the deferred compensation fund that it may be sold, subject to foreclosure, or otherwise disposed of in case of default of repayment of the loan. It requires that the value of liquidity of the security may reasonably be expected to adequately protect both principal and interest on the loan. It also requires that the asset pledged as security for the loan must not be subject to prior and/or superior liens of other creditors in an amount which would negate the value and liquidity of such security for the loan from the fund. Therefore, a provider's evidence of indebtedness, regardless of what the document is called, is, by itself, not security for a loan.

Interest paid by the provider on a loan from the deferred compensation fund is an allowable cost if the necessary and proper requisites are met. Whether a rate of interest is reasonable is determined by comparing it with the rates that would be charged by a bank or other lending institution in the same community on a similar loan. To be similar, the loans should be alike with respect to such factors as amount, duration and security.

Since income earned on loans to the general fund by the deferred compensation fund is not income to the provider, (it is income to the deferred compensation fund), the income earned is not offset against a provider's allowable interest expense. However, before such loans are made, the reasons for such loans should be carefully reviewed to assure that the deferred compensation plan is not serving any purpose other than that for which it was intended, i.e., for the exclusive benefit of participating employees.

Vested Benefits

"Vested" means that at the time the benefits become vested, the employee cannot lose any of the benefits in the fund; i.e., the benefits are not contingent on the employee's continuing services to the employer.

The deferred compensation plan must specify the time and the manner in which the benefits are to become vested, e.g., after a predetermined number of years of employment, or after a specific age is attained, or some combination of the two. The schedule of benefits which accrue to an employee or his survivors upon the employee's retirement, termination of services because of disability, death, or other reasons, must be incorporated into the plan.

The immediate vesting of benefits is not required. However, the deferred compensation plan must provide that vesting of provider contributions occur on or before the normal retirement age established by the provider and defined in the plan.

The unconditional vesting of benefits is not required. Unconditional vesting of benefits means that once a participant's benefits are vested in accordance with the normal vesting schedule, there are no conditions incorporated in the plan which would deprive the participant of such benefits. Accordingly, the forfeiture of an employee's benefits for cause (as defined in the deferred compensation plan) will be recognized provided that such forfeited amounts are used to reduce the provider's subsequent contributions to the deferred compensation plan. However, employee contributions to the deferred compensation fund are always nonforfeitable.

Employee benefits must become fully vested upon any of these occurrences:

1. the normal retirement age established by the provider,
2. termination of the deferred compensation plan,
3. complete discontinuance of contributions under the deferred compensation plan,
4. the termination of the provider's participation in the Medicare program, or
5. change of ownership of the provider where the successor provider is unwilling or unable to continue the deferred compensation plan or alters the existing plan in any way.

Should the provider decline to vest the provider contributions upon the occurrence of any of these events then the funds must be used to reduce the provider's allowable costs.

Benefits to be Paid -- If an employee terminates his or her participation in the deferred compensation plan before his or her rights are vested, the applicable nonvested funds cannot be applied to increase the benefits of the surviving participants, but must be used to reduce the provider's subsequent contributions to the plan. If subsequent provider contributions to the plan are made, then provider costs must be reduced to the extent of such nonvested funds.

Requirements to Fund Plan -- A provider must make its payment to the fund established for the deferred compensation plan within 75 days after the close of the provider's cost reporting period to which a payment applies. If the provider fails to make the payment timely, the allowable cost for payment to the deferred compensation plan must be reduced by the amount which is not paid within 75 days.

Payment in excess of the liability to the plan cannot be included in allowable costs in the year such excess payment is made. Allowable cost is limited to the actual payment made in satisfaction of the provider's current liability to the deferred compensation fund. However, payment to the deferred compensation fund in excess of the provider's current liability may be carried forward and considered as payment against the liability of that future period.

Pension Plans

A pension plan is a type of deferred compensation plan which is established and maintained by the employer to provide systematically for the payment of definitely determinable benefits to its employees usually over a period of years, or for life, after retirement. Such a plan may include disability, withdrawal, option for lump-sum payment, or insurance or survivorship benefits incidental and directly related to the pension benefits. Such benefits are generally measured by and are based on such factors as age of employees, years of service, and compensation received by the employees. A plan designed to provide benefits for employees or their beneficiaries to be paid upon retirement or over a period of years after retirement is considered a pension plan, if under the plan either the benefits payable to the employee or the required contributions by the provider can be determined actuarially.

An employer who desires to provide retirement benefits for his employees may do so in several different ways. The employer may, for example, simply pay pension directly to the employees, that is, without intervention of a trust. He or she may purchase annuities. He or she may establish a pension fund or trust, or may combine any of these.

The Pension Fund

A pension fund is the portion of the pension cost accumulated in the hands of an organization, individual, or trust to be used for the purpose of meeting retirement benefits when they become due.

In order for a plan to be considered funded for purposes of Medicare cost reimbursement, the liability to be funded must have been determined, and the

provider must be obligated to make payments into the fund. Funds existing at the discretion of the provider are not considered valid pension plans. Such plans are treated as direct pension plans, and payments are allowed only when actually paid to the beneficiary.

Where the plan is represented by a fund, the corpus and income therefrom must not at any time be used other than for the exclusive benefit of the employees or their beneficiaries.

Pension Plan Requirements

The plan must meet all the requirements of a deferred compensation plan. (See preceding section and Section 2140ff in the Provider Reimbursement Manual.)

The provider must have available actuarial data containing at least an analysis of the liability for the normal pension cost and the liability for unpaid past service, plus any other appropriate data.

The pension plan must meet the requirements of a formal plan as described in the deferred compensation plan section.

No provision of the plan may discriminate in favor of certain employees, such as employees who are officers, stockholders, supervisors, or highly paid personnel.

Employees' rights must be nonforfeitable after such time as they vest under the plan, that is, not contingent on continuance of employment or other factors.

The past service cost is the greater of the pension cost assigned (under the actuarial cost method in use) to years prior to the inception of a pension plan or the unpaid liability to the fund as of the end of the provider's accounting year ending prior to June 1, 1970. The annual allowance for past services may not be in excess of ten percent of the total cost of the past service liability.

Payments are generally allowed only in the year paid, with these exceptions:

1. If the provider makes allowable payments of annuities or payments into a trust within 75 days after the close of the accounting year, the payment will be considered to have been paid within the year.

The payment must be actual and not constructive. For example, a provider's note payable at a future date will not be considered payment. However, a check will be considered payment if it is good when given and honored when cashed. Similarly, a payment will not be considered paid if all or any part of it is recoverable at the request of the employer.

2. Where the payment made is less than the total unfunded liability outstanding, the payment will be considered to be applied first to the normal cost, that portion applicable to current year's service, and any remainder to allowable unpaid past service liability.

Any amounts paid toward past service liability will be considered as a proportional payment of the entire past service liability, and cannot be allocated to the past service liability of any specific persons or any specific years.

3. Payments made in excess of the limitation above may be allowed in a succeeding year when contributions for that year are less than the limitation. The amounts carried over will be applied as in paragraph two above, regardless of how they would have been treated in the year paid, were there no limitation.
4. Payments made directly to the surviving spouse of an employee, and not out of a fund, will be recognized only if the payments are part of a plan approved by the Internal Revenue Service, and if the deceased employee had neither died nor retired before the effective date of the pension agreement.
5. The payments made by the provider together with all other compensation paid to the employee must be reasonable in amount.

Approval of a pension plan by the Internal Revenue Service does not in itself signify Medicare acceptance of the provider's payments of the plan.

Pension costs are in the nature of general administrative costs and should be so treated on the cost report.

LIFE INSURANCE PREMIUMS

Premiums related to insurance on the lives of officers and key employees where the provider is a direct or indirect beneficiary are not allowable costs.

A provider is a direct beneficiary where, upon the death of the insured officer or key employee, the insurance proceeds are payable directly to the provider.

An example of a provider as an indirect beneficiary is the case where insurance on the lives of officers is required as part of a mortgage loan agreement entered into for a building program, and, upon the death of an insured officer, the proceeds are payable to the lending institution as a credit against the loan balance. In this case, the provider is not a direct beneficiary because it does not receive the proceeds directly, but is, nevertheless, an indirect beneficiary since its liability on the loan is reduced.

Premiums related to insurance on the lives of officers and key employees where the individual's relative(s) or his estate is the beneficiary are considered to be compensation to the individual and are allowable costs to the extent such total compensation is reasonable.

CHAPTER 18

Franchise Fees

Advertising

Membership Costs

Vacation Costs

FRANCHISE FEES

In recent years, a number of firms have entered the field of franchising health care facilities that provide short-term skilled nursing services. A number of franchised facilities are presently participating in Medicare as skilled nursing facilities (SNFs).

The franchise arrangements are usually as follows. In exchange for payment of various franchise fees, the franchisor generally provides a development package, including detailed information on the financing, building, and operation of a nursing home. Thus, the franchisor provides management planning, specialized development services, and continuing operational assistance; while the franchise holder provides the investment, takes the risk, and carries the management responsibility of a private entrepreneur. The franchise holder also receives benefit of the national or regional reputation of the franchisor.

Generally, most of the services provided by a franchisor to an individual franchise holder relate to assistance in the initial phase of a facility's development. The services subsequently provided by the franchisor are, in comparison, of a lesser scope. On the other hand, the fee payments to the franchisor are most substantial after the business is in operation, since under the usual franchise arrangement a continuing percentage of gross revenues is paid to the franchisor for the life of the contract.

The fees charged to a franchise holder generally are:

1. A one-time payment for preliminary analysis (feasibility study) of the site under consideration. This fee is earned by a franchisor even where a franchise is not granted.
2. A one-time license fee when a license or franchise is granted, the amount of which is related to the size of the facility.
3. A continuing royalty fee, generally determined on the basis of a percentage of the gross revenues from routine services and a percentage of gross revenues from ancillary services.
4. A fee related to territorial rights of a licensee to fully develop a specific area, sometimes including the right to issue sublicenses in the area.

Under Medicare, franchised expenses are allowable costs when the circumstances described in the following sections apply. Basically, the provider must identify and value the specific services furnished or made available by a franchisor and for which the provider, as a franchised holder, is claiming franchise fee expenses. The intermediary, in turn, evaluates the fair market value of such services.

Although some franchise fee payments may thus be allowable costs under Medicare, the allowed costs of franchised institutions should not exceed the

costs allowed for similar nonfranchised institutions. Thus, the costs of a franchised institution (including any allowable costs for franchise payments recognized by the program) are not recognized or allowed to the extent they are found out-of-line with similar institutions in the same area.

Feasibility Analysis -- Costs incurred by a provider in determining the feasibility of an institution in an area and in selection of a site are allowable to the extent they are reasonable. Such a service may be furnished to a provider by a franchisor or other organization that performs similar work. In evaluating the reasonableness of the amount, the intermediary considers the complexity of factors involved, the research undertaken, and the expertise of the firm performing the study, as demonstrated by the work product. Under Medicare, these costs are considered in the same category as those incurred for consultant services utilized in planning an institution and are capitalized in the same manner as construction costs. Costs incurred by providers for feasibility studies are not considered franchise fees.

License and Royalty Fees -- Franchise fee payments (license fees and royalty fees) may be recognized as allowable costs to the extent they are related to patient care. To determine the allowability of a franchise fee payment, it is necessary for the provider to demonstrate the extent to which services provided or available under a franchise agreement are related to patient care as opposed to services that help the franchise holder obtain a greater percentage of the market for services in an area.

Excluded from allowable cost is that portion of a franchise fee that is based on the national or regional reputation of the franchisor or that reflects expenses of the franchisor in promoting the organization. Also, excluded are costs related to selling franchises, promotional advertising, and other costs not related to furnishing patient care services covered under Medicare in participating institutions.

To recognize payments by an institution to a franchisor for the right to use a trademark or to benefit from the franchisor's reputation would give a franchised institution a larger reimbursement than other participating institutions in the same area that do not operate under a franchise agreement. These increased costs would be unrelated to providing services to Medicare beneficiaries.

In addition, any franchise payment relating to exclusive franchise rights in a territory or area, including the right to issue sublicenses or authorize licenses within such territory are not allowable costs. Such payments are excluded from allowable costs because they are not related to the production of services or the rendering of patient care.

For example, franchisor "A" licenses middleman "B" to develop franchises in State "C" and to issue sublicenses or franchises to other parties in State "C". Any franchise payment related to territorial rights of middleman "B" or sublicenses through middleman "B" are excluded from allowable costs.

To determine allowable franchise fee payments for each Medicare cost reporting period, it is necessary to determine the amount of franchise payments by a provider to a franchisor and the fair market value of services provided by the franchisor. The amount Medicare recognizes as allowable costs for a reporting period is the lower of the amount determined under either section.

The amount of franchise fee payment made by a provider for the reporting period in question is obtained by determining:

1. the actual royalty fees or other franchise expenses accrued for the reporting period, and
2. the amount of any license fee allocated for the cost reporting period.

The license fee allocation for a reporting period is determined by amortizing any license fee payment made by the franchise holder to the franchisor equally over the full term of the franchise agreement.

The sum of (1) and (2) is the maximum amount of franchise fee expenses that may be attributed to a cost reporting period.

The value of services furnished is the sum of:

1. The reasonable (fair market) value of the services furnished during the cost reporting year,
2. If applicable, the services furnished by the franchisor to the provider before opening of the institution or during a startup period, and
3. The uniform allowable fee for retainer or backup services.

Example: XYZ institution opens April 1, 1978, with a cost reporting period ending March 31, 1979. Prior to opening, the provider paid the franchisor a license fee of \$20,000 and signed a franchise agreement for 16 years. During the period ending March 31, 1979, the provider accrued royalty fee expenses of \$15,000. Based on documentation furnished by the provider and franchisor, the intermediary determined the reasonable (fair market) value of the services furnished during the cost period by the franchisor to the franchised provider as \$10,500. The value of the retainer or backup services was established at \$1,000.

The intermediary also determined that prior to opening, the reasonable value of franchisor services relating to planning, construction, and financing of the institution was \$17,000, and the reasonable value of services attributable to startup services was \$8,000. The determination of allowable franchise fee expenses is as follows:

Cost Reporting Year Ending March 31, 1979

Evaluation of Services

(1) Pre-opening	\$17,000 x 12/192 (months) (16 yrs)	\$ 1,063
(2) Startup	8,000 x 12/60 (months) (5 yrs)	1,600
(3) Current		10,500
(4) Retainer or backup		<u>1,000</u>
Total (a)		<u>\$14,163</u>

Franchise Payments

Amortized license fee payments	\$20,000 x 12/192 (months)(16 yrs)	\$ 1,250
Royalty fee expense		<u>15,000</u>
Franchise fee expense -- Total (b)		<u>\$16,250</u>

Intermediary recognizes lower of (a) or (b) as allowable costs; in this case \$14,163.

Each franchisor's program is evaluated separately because the various franchisors design their package of services differently or have services available of varying quality or scope. Moreover, contract agreements may not be precise as to available services or may refer to services provided in specific "model" institutions. The services actually furnished a franchise may also vary based on its needs.

The intermediary determines whether the management or other services identified and attributed to the cost period are related to patient care, and whether the total amount claimed as allowable costs for these services is reasonable based on the intermediary's knowledge, judgment, and experience and on the expertise of other qualified parties it may consult. The intermediary recognizes as an allowable cost that portion of the franchise fee expenses determined to be the reasonable (fair market) value of services furnished by the franchisor. The provider is responsible for supplying the intermediary with all data needed by the intermediary concerning the relationship between the franchise holder and franchisor.

If the franchisor participated in the planning, financing, and construction of the institution -- as opposed to a franchisor who franchised an already operating institution -- the services furnished during the period before the institution opened are valued by the intermediary at the end of the first reporting period under Medicare and amortized over the term of the franchise agreement.

The same valuation procedure is followed for startup services, except that the amortization period is the same as that for startup costs under Medicare (60 months). Startup services are those related to operating and maintaining the institution from the time the premises are taken over from the builder or previous owners, to the time the first patient is admitted.

The program recognizes as allowable cost a uniform annual amount for the backup or retainer type services available from the franchisor. These "as needed" services include availability of services for training key employees when needed, temporary replacement of an administrator or head of nursing when no replacement is otherwise available to the franchisee, management consultation services, and other backup or assistance services.

The specified uniform amount must be the same for each franchised provider affiliated with the same franchisor. The amount is established on a one-time basis but it is subject to change if the agreement is modified or if there is a change in the scope or nature of available "as needed" or retainer services.

ADVERTISING COSTS

The allowability of advertising costs depends on whether they are reasonable, appropriate and helpful in developing, maintaining and furnishing covered services to Medicare patients. To be reimbursable, such costs must be common and accepted occurrences in the field of the provider's activity. In determining the allowability of these costs, the intermediary should consider the facts and circumstances of each provider situation as well as the amounts which would ordinarily be paid for comparable services by comparable institutions.

Advertising costs incurred in connection with the provider's public relations activities are allowable if the advertising is primarily concerned with the presentation of a good public image and directly or indirectly related to patient care. Examples include visiting hours information, conduct of management-employee relations, etc.

Fund-raising costs, including advertising, promotional or publicity costs incurred for such a purpose, are not allowable.

Costs of advertising for the purpose of recruiting medical and paramedical personnel for the provider's salaried staff are allowable. Costs incurred in advertising for administrative or clerical personnel are allowable if the personnel would be involved in patient care activities or the development and maintenance of the facility.

Costs of advertising for procurement of scarce items or services related to patient care, and for sale or disposition of surplus or scrap material may be treated as adjustments of the purchase or selling price.

Advertising costs incurred in connection with obtaining bids for construction or renovation of the provider's facilities should be included in the capitalized cost of the asset.

Advertising costs incurred in connection with bond issues are allowable when the proceeds of the bonds are designated for purposes related to patient care, i.e., construction of new facilities or improvements to existing facilities. The advertising costs are included in "Bond Expenses" and are pro-rated over the life of the bonds.

Advertising costs incurred in connection with the issuance of a provider's own stock, or the sale of stock held by the provider in another corporation, are considered as reductions in the proceeds from the sale and are not includable in allowable costs.

While costs of advertising for the purpose of recruitment of physicians as members of the provider's salaried staff are allowable, costs of advertising of a general nature designed to invite physicians to utilize the provider's facilities in their capacity as independent practitioners are not allowable.

Costs of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable. There may be situations where advertising which appears to be in the nature of the provider's public relations activity is, in fact, an effort to attract more patients. An analysis by the intermediary of the advertising copy and its distribution may then be necessary to determine the specific objective. While it is the policy of the Health Care Financing Administration and other Federal agencies to promote the growth and expansion of needed provider facilities, general advertising to promote an increase in the patient utilization of services cannot properly be related to the care of patients.

On the other hand, reasonable costs of activities involving professional contacts with physicians, hospitals, public health agencies, nurses' associations, State and county medical societies, and similar groups and institutions, to apprise them of the availability of the provider's covered services are allowable. In addition, such contacts are useful as an exchange of medical information, administrative and medical policy, utilization review, etc.

Similarly, reasonable production and distribution costs of informational materials to professional groups and associations, such as those listed above, are allowable if the materials primarily refer to the provider's operations and financial position, or contain data on the number and types of patients served. Such materials should contribute to an understanding of the role and function of the facility as a provider of covered health care in the community.

The cost of listing the facility in a telephone directory or in a directory of similar facilities in a given area is allowable.

MEMBERSHIP COSTS

Providers customarily maintain memberships in a variety of organizations and consider the costs incurred to be ordinary provider operating costs.

Some of these organizations promote objectives in the provider's field of health care activity. Others have purposes or functions which bear little or no relationship to this activity. In order to determine for Medicare purposes the allowability of costs incurred as a result of membership in various organizations, memberships have been categorized into three basic groups: (1) professional, technical or business related; (2) civic; and (3) social, fraternal, and other.

Professional, Technical, or Business Related Organizations

The Medicare program classifies organizations in this category if their functions and purposes can be reasonably related to the development and operation of patient care facilities and programs, or the rendering of patient care services. Memberships in these organizations, while not restricted to providers, are generally comprised of provider, provider personnel, or others who are involved or interested in patient care activities.

Costs of memberships in such organizations are allowable for purposes of program reimbursement. These costs include initiation fees, dues, special assessments, and subscriptions to professional, technical or business related periodicals. Also included are costs related to meetings and conferences, such as meals, transportation, registration fees, and other costs incidental to these functions, when the primary purpose of such meetings and conferences is the dissemination of information for the advancement of patient care or efficient operation of the facility.

Civic Organizations

These organizations function for the purpose of implementing civic objectives. Reasonable costs of initiation fees, dues, special assessments, and subscriptions to periodicals of civic organizations are allowable. Also allowable are those reasonable costs related to meetings and conferences, such as meals, transportation, registration fees, and other costs incidental to these functions when the primary purpose of such meetings and conferences is the promotion of civic objectives.

Social, Fraternal, and Other Organizations

Generally, these organizations concern themselves with activities unrelated to their members' professional or business activities. Their objectives and functions cannot be considered reasonably related to the care of beneficiaries. Consequently, provider costs incurred in connection with memberships in social, fraternal, and other organizations are not allowable.

VACATION COSTS

Providers have different policies with regard to employee vacations. Vacations may be granted after the employee has worked a minimum period, e.g., after six months or after one year. The length of time allowed for vacations may remain the same or may be increased based on the length of service; the vacation must be taken; or payment may be made to the employee in lieu of his taking a vacation; or any combination of these and other factors.

Vacation costs must meet all of the following conditions to be included in allowable costs.

1. These costs must be included in the cost reporting period in which they are earned by the employee and must be computed from actual payroll records as related to each employee.

2. Where the provider's vacation policy is consistent among all employees, the vacation must be taken - or, if the employee elects to be paid in lieu of taking a vacation, the payment must be made - within the period consistent with the vacation policy established by the provider.

Where the policy is not consistent among all employees, the vacation must be taken - or payment in lieu of vacation must be made - within two years after the close of the cost reporting period in which the vacation is accrued.

If payment is not made within the required period of time, the current year cost report must be adjusted accordingly. Likewise, where accrued vacation benefits are included in allowable costs and are forfeited by the employee for cause, the current year cost report must likewise be adjusted.

NOTE: If the vacation is taken by an owner, or if he receives amounts in lieu of a vacation, the two-year time limit applies rather than the 75-day limit for owner's compensation specified in Section 906.4 of the Provider Reimbursement Manual. The two-year limit applies only to vacation pay.

3. Amounts allowed for vacation benefits must be reasonable in themselves and, together with other compensation, result in reasonable compensation for services rendered.

Employer payroll taxes applicable to vacation, such as F.I.C.A., must not be accrued in the period when the vacation costs are accrued but treated as a cost in the period when the vacation costs are paid.

Conversion from Cash Method to Accrual Method for Vacation

Sometimes a provider wants to change its vacation cost accounting from a cash method to an accrual method. Usually this change to the accrual method is made because the provider thinks there may be a substantial increase in the amount of Medicare reimbursement it will receive in the year of the change. The adjustments made to effect the change must be reviewed carefully in order to prevent costs from being duplicated or omitted in the cost reporting period in which the change is made.

The accrual must be based on the vacation policy as established by the provider. No accrual will be allowed where an employee forfeited a vacation under the provider's vacation policy and for which the provider did not incur a liability.

As part of the conversion to the accrual method, an adjustment must be made for the amount of vacation costs included in the cost report in the first year the provider entered the Medicare program. The adjustment is applicable to the amount of vacation costs of prior periods which was included in the provider's costs in the first year under the Medicare program.

(See Section 2146 in the Provider Reimbursement Manual for technical details and an example of conversion of vacation pay from the cash basis to the accrual basis.)

CHAPTER 19

Taxes

Franchise Taxes

Unemployment Compensation Insurance Taxes

TAXES

Taxes which are levied by States, counties, cities, and other levels of government are generally allowable costs. However, any fines or penalties related to the taxes are not allowable. The provider is expected to take advantage of any exemptions to taxes which are legally available. If the provider does not take advantage of available exemptions, the taxes are not allowable costs under the program.

Certain taxes which are levied on providers are not allowable costs. These taxes are:

1. Federal income and excess profit taxes, including any interest or penalties paid thereon (see PRM Section 1217).
2. State or local income and excess profit taxes (see PRM Section 1217).

(Income taxes are not allowable costs because income taxes are taxes on profits. Since Medicare reimbursement is based on reasonable costs, a tax on profits in excess of costs is not considered a cost of doing business.)

3. Taxes in connection with financing, refinancing, or refunding operations, such as taxes on the issuance of bonds, property transfers, issuance or transfer of stocks, etc. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are not, however, recognized as tax expense.
4. Taxes from which exemptions are available to the provider.
5. Special assessments on land which represent capital improvements such as sewers, water, and pavements, should be capitalized and depreciated over their estimated useful lives.
6. Taxes on property which is not used in the rendition of covered services.
7. Taxes, such as sales taxes, levied against the patient and collected and remitted by the provider.
8. Self-employment (FICA) taxes applicable to individual proprietors, partners, members of a joint venture, etc.

Employment-related taxes, i.e., FICA, Workers' Compensation and Unemployment Compensation, which are paid by a provider on behalf of provider-based

physician, are considered business expenses of the employer and not fringe benefits. Hence, they are includable in their entirety as part of the administrative cost of the provider, without allocation to the physician's professional component. Such taxes are reimbursable to the provider on a reasonable cost basis.

FRANCHISE TAXES

A franchise tax is a periodic assessment levied by a State or local taxing authority on the operation of a business. The basis used to compute the amount of the franchise tax varies among taxing authorities. The franchise tax may be based on net income of the provider or on capital stock issued, or it may simply be a license to engage in business, or a combination of all of these factors.

Where the amount of the franchise tax is based upon the net income of the provider, with a minimum amount stated, the following criteria will be used to determine whether, and in what amount, a franchise tax is allowable cost:

1. Where a provider has no net income but is required to pay a minimum franchise tax, the franchise tax is an allowable cost.
2. Where a provider realized net income which is not sufficient to incur a tax in excess of the minimum tax and the minimum tax is levied, then only the difference between the minimum franchise tax and the tax computed on net income is an allowable cost. For example, if the minimum tax is \$500 and the tax computed on net income is \$400, then the \$400 is an income tax and only the excess (\$500 - \$400) or \$100 is an allowable cost.
3. Where a provider has net income sufficient to incur a tax greater than the minimum franchise tax, the entire tax is considered an income tax and no part of the tax is an allowable cost. For example, if the minimum tax is \$500 and the tax computed on income is \$600, then the entire \$600 is a nonallowable cost.
4. Where the amount of the franchise tax is based upon several criteria, one of which is net income, the amount of the franchise tax computed on net income is not an allowable cost. For example, if the minimum tax is \$500, the tax computed on net income is \$400, and the tax levy on capital stock is \$600, then \$400 remains an income tax and only excess (\$600 - \$400) or \$200 is an allowable cost.

UNEMPLOYMENT COMPENSATION INSURANCE TAXES FOR NONPROFIT PROVIDERS

Most nonprofit providers and State hospitals are required to cover certain employees under their respective State unemployment compensation laws under Federal Public Law 91-373. This Federal law also provides that each nonprofit provider must be permitted by State law the option of:

- (1) paying regular State unemployment compensation taxes, or
- (2) reimbursing the State directly, on a dollar-for-dollar basis, for unemployment compensation benefits paid to former employees attributable to service with the provider. This is a form of self-insurance.

Where a nonprofit provider elects to pay regular State unemployment compensation taxes, such payments are recognized as an allowable cost.

Where a nonprofit provider chooses to self-insure by establishing its own reserve account, contributions to this reserve account are not allowable costs under the Medicare program. Certain costs associated with a self-insurance program are allowable, whether paid from the fund or directly by the provider. They are:

1. Any amounts paid to reimburse the State for unemployment-compensation payments actually made by the State to the former employees of the provider.
2. Any premium costs for the purchase of commercial insurance which protects against catastrophic loss, provided the type, extent, and cost of coverage are not substantially out of line with those of other similar institutions in the same area.
3. The fees paid to an outside individual or firm to administer the program, to the extent such fees are considered reasonable for the services rendered. Such administration may consist of completing the claims forms from the State unemployment office, representing the provider at the appeals level, etc.
4. Any other reasonable administrative costs incurred by the provider in establishing and administering the program.

These costs are allowable for a chain organization program to the extent the costs are properly allocated among the providers which incurred them, e.g., unemployment compensation payments should be directly allocated to the provider whose unemployed employees were paid.

Where a nonprofit chain organization (or related organization) centrally operates an unemployment insurance reserve fund for some or all of its member (related) providers, the fund is considered a self-insurance program and payments made to it by the participating providers are not allowable costs under the Medicare program. This is because such a fund is simply an arrangement among related providers with the chain maintaining control over the fund. Thus, payments to the fund are not actually incurred costs, but rather a provision for establishing a central reserve from which unemployment costs are met as they are incurred.

Any income earned from investment of the funds of the reserve account must be used to offset a provider's allowable interest expense under the Medicare program.

NOTE: Unemployment compensation insurance taxes paid by proprietary for-profit providers under their respective State unemployment compensation laws are reimbursable costs.

CHAPTER 20

Value of Services of Nonpaid Workers

VALUE OF SERVICES OF NONPAID WORKERS

The question of the value of services of nonpaid workers was raised early in the Medicare program because of the many religious orders that operate hospitals throughout the country. Sisters and other members of the religious order often perform duties which are usually performed by lay workers in other hospitals. These duties, primarily in the administrative and nursing areas, are performed without payment of salaries or wages.

The following principle has been applied to determine the value of such services by nonpaid workers.

If a nonpaid worker works more than 20 hours per week in a full-time position which would normally be occupied by a paid worker, the value of services performed by the nonpaid worker is allowable in reimbursable costs as an operating expense. The nonpaid workers must be members of the organization which has made arrangements with the provider for such services to be rendered by the nonpaid workers.

In effect, the Medicare program will reimburse the hospitals the equivalent salaries and related benefits of paid workers where there is a written contract between the Motherhouse and the hospital providing for actual payment for the services rendered. However, the cost of maintenance of the nonpaid workers must be subtracted from the reimbursable cost.

Guidelines

Nonpaid workers must work more than 20 hours per week in any of the types of full-time positions that are normally occupied by paid workers of providers not operated by or related to religious orders.

Services must be related directly to patient care or in administrative positions essential to the provision of that care, e.g., nursing care or essential office, admitting, switchboard operations. Where the provider would not ordinarily hire others to perform the services of the nonpaid workers, the value of the nonpaid work is not reimbursable.

Services not related to patient care or in administrative positions not essential to the provision of that care, such as distributing books and magazines to patients, or services performed in a provider canteen, cafeteria or gift shop, are not reimbursable. Moreover, services rendered gratis by volunteers such as those affiliated with the American National Red Cross, hospital guilds, auxiliaries, and similar organizations are not reimbursable. Such services have traditionally been rendered on a purely volunteer basis without expectation of any form of reimbursement by the organization through which the service is rendered, or by the person rendering the service.

Services necessary for normal patient care and operation of the provider, traditionally rendered by sisters and other members of religious orders under arrangements whereby the provider makes bona fide payment to the organization of nonpaid workers, have generally been reimbursed by third parties which pay hospitals on a cost basis. The value of these services is includable in allowable costs under the Medicare program.

The amount per individual recognized in reimbursable costs for the imputed value of services of nonpaid workers cannot exceed the amount per individual allowed for paid employees (based on regular working hours -- excluding overtime) who perform similar services. Hours worked by the nonpaid worker in excess of the regular working hours of the comparable paid employee cannot be recognized in reimbursable costs even when the paid employee works overtime.

Where the services of a nonpaid worker are performed in a position unlike any other full-time position in the provider's organization, the amount allowed in reimbursable costs cannot exceed the amount paid for such services by other providers in the area of similar size, scope of services, and utilization. The value of similar services necessarily includes actual salaries paid based on regular hours (excluding overtime hours), and regular rates of pay, plus the costs of maintenance, perquisites, and fringe benefits for paid employees. (Examples: maintenance -- room and board; perquisites -- free uniforms and laundry; fringe benefits -- vacations, holidays, sick leave, and discounts below cost on hospital bills and drugs.)

The reasonable costs actually incurred by a provider in furnishing fringe benefits, perquisites, and maintenance to a nonpaid worker may be included as allowable costs not to exceed the total allowable costs (including salary) for similar services rendered by the paid employee. This rule is in effect regardless of whether or not any of the same fringe benefits, perquisites, and maintenance are furnished to a paid employee in a similar position. The total of these costs incurred on behalf of the nonpaid worker is then subtracted from the total allowable costs including salary for similar services rendered by the paid employee. Any positive difference is the net imputed value for the nonpaid worker. This net imputed value is allowable to the extent that the provider is under contractual obligation to pay the organization of nonpaid workers. Any payments made by the organization of nonpaid workers to the provider for the nonpaid workers' maintenance, perquisites or fringe benefits must be used as an offset to the total of such costs actually incurred by the provider. (See following example.)

The value of fringe benefits should be based on those fringe benefits furnished a paid employee whose hours of work are comparable to those of a nonpaid worker. Where a nonpaid worker's hours are comparable to those of a part-time employee, the value of fringe benefits allowed in establishing the value of the services of the nonpaid worker must be based on the value of fringe benefits to the part-time employee.

Certain costs incurred on behalf of paid employees will not normally be included in determining the value of the nonpaid workers' services. These costs include social security taxes, workmen's compensation, State unemployment insurance, and any other costs stemming from legislative requirements. However, when the provider actually makes payment to the regulatory agency on behalf of the nonpaid worker, these costs may be included as allowable costs in computing the value of the nonpaid worker's services.

<u>Example:</u>	<u>Paid Worker</u>	<u>Nonpaid Worker</u>
Hours worked (excluding overtime)	<u>2,080</u>	<u>2,080</u>
Salary	\$ 6,500	
Fringe Benefits	200	200
Perquisites	100	100
Maintenance	<u>200</u>	<u>450</u>
<u>TOTAL</u>	\$ 7,000	\$ 750

Computation of Net Imputed Value of Services of Nonpaid Worker

Total salary plus fringe benefits, etc.,
paid to paid worker \$ 7,000

Less: Total salary plus fringe benefits, etc.,
paid for nonpaid worker \$ 750

Minus: Amount received from
Motherhouse 250

Net Amount 500

Net Imputed Value \$ 6,500

Payments for nonpaid workers made under a recognized pension plan to either a provider's pension fund or to the organization of nonpaid workers where the payments match the provider's pension costs for paid employees are recognized as an allowable cost. No payments will be includable in allowable costs for nonpaid workers after the age specified for retirement in the pension plan has been reached.

The qualifications of nonpaid workers must be comparable to the qualifications of paid employees performing identical services.

A provider must maintain proper records for the reimbursable services performed by nonpaid workers, identifying established full-time positions and rates of pay in a manner equivalent to the identification in the payroll record for a paid employee of the provider.

The full amount developed, under the terms of the agreement between the organization of nonpaid workers and the provider, for services rendered to the provider by the nonpaid workers must be entered in the provider's accounts even though only a portion may apply to the Medicare program.

It is possible that the Medicare program's cost finding requirements may not result in an appropriate allocation of overhead costs to the nonpaid workers' cost center. Other bases which result in a more accurate allocation may be used for the purpose of determining the costs of nonpaid workers only, providing the bases meet the approval of the intermediary. This applies regardless of the method of cost finding used by the provider.

The intent of cost finding is to approximate as nearly as possible the results that would have been obtained had the provider assigned each specific incident of cost to the cost center in which it was incurred. However, if a provider desires to analyze its costs to determine those amounts which apply to nonpaid workers, this is acceptable as a more precise measurement, provided adequate auditable documentation is available to support the results. Estimates of such costs in lieu of analysis will not be acceptable. Where the provider uses analysis as a means of assigning a cost center's cost to other cost centers, then the analysis should extend to all elements of the cost center being analyzed. If the provider cannot demonstrate that the "analysis" method properly identifies the cost of the nonpaid workers' cost center, it must utilize normal cost finding procedures, subject to the usual bases of allocating costs.

Alternative methods for determining the costs of nonpaid workers have been suggested which are not acceptable to the Health Care Financing Administration (HCFA). The concept of incremental costs by which only the additional costs, resulting from the extension of services to accommodate nonpaid workers would be considered applicable to the nonpaid workers' cost center cannot be used for Medicare purposes. Nor will the program recognize a substitute for the actual depreciation base of the facilities occupied.

The following general rules apply in determining the allowable and nonallowable costs of nonpaid workers:

1. If a provider incurs actual costs for similar or equal fringe benefits, perquisites, and maintenance for both nonpaid workers and comparable paid workers, such costs are allowable costs;
2. If a provider incurs actual costs for fringe benefits, perquisites, and maintenance for paid workers but does not incur actual similar or equal costs for nonpaid workers in comparable positions, then the value of these items plus the salary for the paid worker may be determined and added to allowable costs;
3. If a provider incurs actual costs for nonpaid workers for fringe benefits, perquisites, maintenance or any other expenses in excess of total allowable costs incurred on behalf of comparable paid employees in similar positions, i.e., salary plus fringe benefits, perquisites, maintenance, then the excess costs are nonallowable costs.

As stated earlier, nonpaid workers must be members of the organization of nonpaid workers which has made arrangements with the provider for the performance of services by nonpaid workers. Membership in the organization must be

substantiated by adequate documentation in the files of the organization of nonpaid workers. There must exist a legally enforceable agreement between the provider and the organization of nonpaid workers establishing the obligation to pay the organization for services to be rendered.

The agreement would not be legally enforceable, however, if the organization of nonpaid workers agreed to pay, repay, or make a contribution to the provider for all or part of the salary liability. The amount paid by the organization of nonpaid workers to pay the provider's salary liability would be used to reduce the allowable net imputed value.

The provider will be deemed to have discharged its liability under the legally enforceable agreement when the provider makes payment equal to the net imputed value in one of the following ways:

1. Makes payment by check or cash to the organization of nonpaid workers;
2. Issues a negotiable instrument (note) to the organization;
3. Legally transfers assets, such as stocks, bonds, real property, etc., to the organization. The amount of payment will be based on the fair market value of the assets transferred. Such value shall be determined at the time of the transfer.
4. Accepts a written statement from the organization of nonpaid workers disclosing that the organization is voluntarily donating to the provider a part or all of the salary liability; the provider must make the proper book entries, and retains in its files documentation to substantiate the donation and its nature.

The organization of nonpaid workers must obtain a tax exempt status from the U.S. Internal Revenue Service.

Reimbursable costs cannot include any imputed value (i.e., any expenses not actually incurred) for the services of a worker who has received any direct remuneration (salaries, wages, or gifts) from the provider or from the organization of nonpaid workers. Where a worker receives direct remuneration from either organization, he cannot be considered a nonpaid worker under this principle.

CHAPTER 21

COST OF EDUCATIONAL ACTIVITIES

Interns and Residents

COST OF EDUCATIONAL ACTIVITIES

Medicare believes the responsibility for operating and supporting approved educational programs which are necessary to meet the community's needs for nursing and paramedical personnel should be borne by the community. Where the community has not yet recognized and accepted this responsibility, the Medicare program does participate appropriately in the support of such approved programs which are operated by providers in conjunction with their patient care activities. A proportionate part of the net cost of approved educational activities is, therefore, an allowable cost.

Approved educational activities means formally organized or planned programs of study engaged in by staff members of a provider, as distinguished from "on-the-job," "inservice," or similar work-learning programs. To be an allowable cost, the educational activity must be:

1. Designed to enhance the quality of health care in the institution, or to improve the administration of the institution;
2. Where required, licensed by State law;
3. Where licensing is not required, approved by the recognized professional organization for the particular activity.

APPROVED PROGRAMS

The Medicare program has recognized approved medical, osteopathic, dental, and podiatry internships and residency programs. In addition, the program has recognized the following professional and paramedical education and training programs conducted by provider institutions and their approving bodies:

Program

Approving Bodies

- | | |
|--|--|
| 1. Cytotechnology | Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists |
| 2. Dietetic internships | The American Dietetic Association |
| 3. Hospital administration residencies | Members of the Association of University Programs in Hospital Administration |

<u>Program</u>	<u>Approving Bodies</u>
4. Inhalation therapy	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Inhalation Therapy
5. Medical records	Council on Medical Education of the American Medical Association in collaboration with the Committee on Education and Registration of the American Association of Medical Records Librarians
6. Medical technology	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists
7. Nurse anesthetists	The American Association of Nurse Anesthetists
8. Professional nursing	Approved by the respective State approving authorities. Reported for the United States by the National League for Nursing
9. Practical nursing	Approved by the respective State approving authorities. Reported for the United States by the National League for Nursing
10. Occupational therapy	Council on Medical Education of the American Medical Association in collaboration with the Council on Education of the American Occupational Therapy Association
11. Pharmacy residencies	American Society of Hospital Pharmacists

12. Physical therapy

Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association

13. X-ray technology

Council on Medical Education of the American Medical Association in collaboration with the American College of Radiology

ALLOWABLE COSTS

The net cost means all of the costs, both direct and indirect, of approved educational activities, including stipends of trainees, compensation of teachers, and other costs, reduced by any reimbursements from grants, tuition and donations received for educational purposes.

The net cost of approved educational activities, however, cannot include any cost of usual patient care, i.e., care which is medically reasonable, necessary and ordinarily furnished in the treatment of patients.

Example: A hospital has set aside beds as a teaching unit and residents of the hospital's approved educational program generally provide the physician care for the Medicare and non-Medicare beneficiaries occupying these beds. The hospital wishes to consider as educational costs the unrecovered cost or charges of usual patient care rendered to these patients.

It must be recognized that there are two components of cost in furnishing services to these teaching patients -- net educational costs and usual patient care costs. A hospital may not allocate the unrecovered cost or the unrecovered charges of usual patient care for this unit as an educational cost. If this allocation is made, Medicare would be reimbursing the provider for services furnished non-Medicare beneficiaries. Medicare reimburses its share of the patient care for this unit in the same way it reimburses for patient care services of other patients in the hospital.

INTERNS AND RESIDENTS

1. Under Approved Teaching Program

To be allowable, a medical internship or residency training program must be approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association.

Intern or residency programs in the field of dentistry in a hospital or osteopathic hospital must have the approval of the Council on Dental Education of the American Dental Association.

For cost reporting periods beginning after December 31, 1972, the costs of a teaching program for interns or residents in the field of podiatry and the costs of services they render are allowable costs if the program is approved by the Council of Podiatry Education of the American Podiatry Association.

2. Not Under Approved Teaching Program

Some institutions employing interns and residents may not have any teaching programs. In such cases the cost of services furnished Medicare patients by the interns and residents are reimbursable under Part B as physicians' services. In these cases there are no educational costs.

Other institutions employing interns and residents may have unapproved teaching programs. The costs of services furnished by these interns and residents are covered under Part B as physicians' services but the costs of the unapproved educational program are not allowable under Part A or Part B. Administrative costs related to teaching activities incurred by physicians or others involved in unapproved educational teaching programs must be reduced by the appropriate amount applicable to these teaching activities. Such adjustments may be made on the basis of time records, if available, schedules established for teaching sessions, or on the provider's estimate of time spent by physicians or others.

REIMBURSEMENT FOR COSTS OF INTERNS AND RESIDENTS

1. Reimbursement under Part A -- Where a hospital has an approved teaching program, the cost of services of interns and residents to inpatients is includable in allowable costs under Part A. Likewise, in a skilled nursing facility (SNF) which has a transfer arrangement with a hospital which has an approved program, the cost of services of interns and residents to inpatients is allowable.

Where home health services are furnished by residents or interns under approved teaching programs of the hospital with which the home health agency is affiliated or under common control, the visiting costs incurred by the interns or residents of the hospital for visits to home health patients are included in the allowable costs of the home health agency.

2. Reimbursement Under Part B -- The following types of services performed by interns or residents are reimbursable under Part B on a reasonable cost basis:

- A. Services rendered to inpatients of hospitals by interns and residents not in approved training programs;
- B. Services performed for hospital outpatients;

- C. Services which would otherwise be covered under Part A, but for which the patient is not eligible under Part A (e.g., inpatient hospital benefit eligibility is exhausted);
- D. Services performed for SNF patients which are not covered under Part A; and
- E. Services performed for home health patients which are not covered under a Part A home health plan.

The cost of residents' and interns' services to inpatients under Part B is calculated on a per diem basis by the hospital in consultation with the intermediary. The total cost of such services (including fringe benefits, etc.) is apportioned between inpatient and outpatient services on the basis of the time spent on each. The inpatient per diem figure is then obtained by dividing the total annual inpatient cost for these services by the estimated annual number of inpatient days for all patients.

For patients who are enrolled under Part B, the provider is reimbursed for 80 percent of the cost of providing these services. The provider should collect from the patient 20 percent of the per diem rate for the services multiplied by the number of inpatient days used.

Patients not enrolled under Part B are liable for the entire cost of Part B interns' and residents' services. The provider must maintain a record of the inpatient days of these individuals so that this cost may be excluded from the amount of program obligation at the time of retroactive cost adjustment.

For information on coverage of services performed by interns and residents, refer to the appropriate manuals listed below:

Hospital Manual - Sections 210.6, 237

Skilled Nursing Facility Manual - Section 212.7

Home Health Agency Manual - Section 206.4

As stated at the beginning of this chapter, Medicare believes that the responsibility for operating approved educational programs for nursing and paramedical personnel should be a community responsibility. Where the community has not yet accepted this responsibility, the Medicare program does participate in the support of such approved programs which are operated by providers in conjunction with their patient care activities.

It is not intended, however, that Medicare should be responsible for expenditures by a provider in subsidizing such programs that are operated by other organizations. Under Medicare principles of reimbursement, an approved nursing or paramedical education program must be operated by a provider (or

jointly by a group of providers) for students of the provider before Medicare will recognize the costs of the program as allowable costs of the provider.

Where a provider furnishes financial or other support (e.g., donated classroom or clinical space) to an approved nursing or paramedical education program of which the provider is not the legal operator, expenses attributable to the provider's support of the program are considered to be a contribution to a community effort, and may not be included in the hospital's allowable costs for Medicare reimbursement purposes.

EXAMPLE: A hospital furnishes support to approved Registered Nurse (RN) and Licensed Practical Nursing (LPN) education programs but is not the legal operator of these programs. The RN program is operated by a local university and the Licensed Practical Nurse program is operated by the county public school system. The students in both programs are enrolled as students of these organizations rather than of the hospital. The facilities and financial support needed to operate the programs come from various sources. The hospital allows its facilities to be used for the clinical training of students in both programs and, in addition, makes an annual cash contribution to the RN program. The remaining costs of the programs are met through the use of county and State tax revenues and other funds received by the programs' operators.

Operational responsibility for the RN and LPN programs is considered to be borne by the community. The hospital's contribution and costs attributable to the donated clinical facilities and supplies, is considered to be a contribution to a community effort which may not be included in the hospital's allowable costs for Medicare reimbursement purposes.

There is, however, an exception to this rule. Since the students in the nursing education programs receive their clinical training on location at the hospital, costs the hospital incurs for patient care services furnished by the students during this part of their training are includable in the hospital's allowable costs.

Another example of an educational program for which costs may be allowable is a program where nurses are sent to college by the hospital to obtain Bachelor of Science degrees in nursing, related health care fields, or other advanced training courses in such subjects. The hospital usually requires that the nurses work for the hospital for a specific period following completion of the program. If there is any question about whether the program is allowable, the intermediary makes the determination.

Some providers which are county, State, or Federally owned and operated receive subsidies from these governmental bodies. The subsidies are usually general in nature and are not restricted to payments for a specific element of cost. The provider may spend all or part of the unrestricted subsidy for approved educational purposes. Under such circumstances, the appropriate part of educational expense may be included in allowable costs and need not be reduced by the funds received from the governmental body.

On the other hand, a provider may receive subsidies that are restricted by the State or local government to further a specific education program of the provider. Funds so received, regardless of their source, must be treated as reductions of the educational expense of the provider.

Revenues received through tuition and scholarships are offset against educational expenses. Reimbursement from provider employees for meals, uniforms, books or supplies are offset against educational costs; or they are offset against the account to which the expense was charged.

The expenses of a medical library, including the salaries of librarians, supplies, books, periodicals, etc., are allowable costs.

Costs for the planning and conduct of refresher and post-graduate programs related to the improvement of patient care for medical and paramedical personnel of the local area and surrounding communities are allowable. For example, the cost of courses given for the purpose of inducing the return to active service of nurses and technicians who have been out of the field for an extended period would be properly included in allowable costs.

Costs of part-time education for bona fide full-time employees at properly accredited academic or technical institutions devoted to undergraduate and/or graduate work are allowable costs provided that:

1. Allowable costs are limited to expenses incurred for training materials, text books, and tuition charges by the educational institutions.
2. The employee agrees in writing to complete the course of training and to continue in the provider's employ for a reasonable period, usually not less than six months, following completion of the course of study.

Travel expense incurred by a provider to send employees to attend an educational workshop which increases the quality of medical care and/or the operating efficiency of the institution is an allowable cost. Workshops on medical techniques, health applications, data processing, hospital accounting and cost finding, and other administrative activities are examples of the types of workshops for which travel expense will be recognized.

Costs will be allowed if they are incurred for training in the use of medical appliances by the following: (1) the patient; (2) members of the patient's family; or (3) other individuals whose responsibility will be to care for the patient after discharge.

CHAPTER 22

Physicians Guaranteed Standby
Fees in Hospital Emergency Rooms

Nonphysician Anesthetist Services

REIMBURSEMENT OF HOSPITAL EMERGENCY ROOM SERVICES WHEN PHYSICIANS RECEIVE GUARANTEED STANDBY FEES

Hospitals sometimes make arrangements with physicians to have the physicians take care of patients in the hospital emergency room. The physicians may either have the hospital bill the patients on their behalf or they may bill the patients directly.

Under either billing arrangement, the hospital may guarantee the physicians a minimum amount of compensation for being available on a standby basis to handle emergencies. It is possible that the total charges billed by or on behalf of the physicians may fall short of the guaranteed amount. When this occurs, the hospital is obligated to pay the physician the difference between the charges made for his services and the guarantee.

Regardless of the formal terms of a specific agreement, the following conditions must always be met in order to recognize an unmet guaranteed amount as a hospital cost for Medicare reimbursement purposes:

1. The guaranteed level of compensation must be reasonable in relation to the amount of time the physician is physically present on the hospital premises;
2. The guaranteed level of compensation must also be reasonable in relation to the total physician charges which could generally be expected to be derived during the time the physician is physically present on the hospital premises;
3. Any income realized by the hospital in excess of its payments to the physician must be used as an offset against hospital costs. In determining income, gross charges are not to be reduced by charity, courtesy, or any other similar allowances. In other words, income means physicians' gross charges minus bad debts and contractual allowances;
4. The Part B charges by the physician must be reasonable in relation to the patient services rendered and not merely token charges. Where the agreement restricts the physician from charging for selected groups of patients, imputed charges for such services must be included. (The example at the end of the section includes an imputed charge.);
5. The arrangement must be bona fide, not merely a device for the coverage of physician services as hospital costs. For example:

Dr. X bills his emergency room patients his customary charges. He is also required under this contract to render services to inpatients on an emergency basis if the patient's physician is unavailable, or to render services at no charge to the employees of the hospital. However, Dr. X's contract does not permit him to bill the latter two classes of patients.

In order to determine whether any costs are reimbursable to the hospital under the guarantee, a reasonable dollar value must be assigned (i.e., imputed) to all services rendered by Dr. X. This amount could be that which Dr. X would have charged had he been allowed to bill, or the charge reflected in the hospital's general schedule of charges for such services to all patients.

6. All charges should be included in a determination of whether the hospital has met the guarantee for the services of emergency room physicians.

When the physician's agreement limits his or her direct patient care services to the emergency room only, the amount that may be recognized in determining hospital costs is the reasonable amount guaranteed the physician less the total charges for the services the physician provided to all patients, non-Medicare, as well as Medicare. All charges are included, regardless of whether an attempt was made to bill or collect for such services. The hospital must keep a record of all physician charges rendered to emergency room patients.

These costs are reimbursed under Part B and are processed by the Part A intermediary.

When the physician's agreement requires him to render direct patient care services to both emergency room outpatients and the hospital inpatients, the amount that may be recognized in hospital cost is the reasonable amount guaranteed the physician less the total charges for the services the physician provided to all outpatients and all inpatients, non-Medicare as well as Medicare, regardless of whether an attempt was made to bill or collect for such services. The hospital must keep a record of all charges for services rendered to inpatient and emergency room patients.

Costs incurred by the hospital are reimbursable under Part A if attributable to inpatient services and Part B if attributable to services in the emergency room or outpatient department. The costs should be distributed between Part A and Part B in the same ratio that inpatient charges and emergency room charges bear to total charges. (See example at end of the section.)

When a contract requires the physician to render duties other than direct patient care services, such as teaching, administrative, supervising technical personnel, etc., which are of general benefit to all patients, and the hospital incurs recognizable costs for such activities, the intermediary will distribute these costs between the Part A and Part B programs in the same ratio that the inpatient charges and charges for emergency room bear to total charges. Costs incurred by a hospital for physicians' time spent on standby are allocable on the same basis. For example, if 85 percent of the total charges are generated from emergency room services, 85 percent of the costs should be allocated to Part B.

The unmet guarantee, as described in this section, is the only type of financial arrangement in which the Medicare program will recognize standby costs for payments made to emergency room physicians.

Example:

City Hospital guarantees Dr. Jones \$25,000 per year for nighttime emergency standby services. He bills his customary fee to outpatients but must also handle occasional in-house emergencies if the patient's physician is unavailable. However, he cannot charge for the latter. During the year, Dr. Jones' actual billings for outpatients total \$22,000. To determine if the guarantee is met:

STEP 1: Assign a dollar (i.e., imputed) value to the in-house emergencies handled but not billed, and add this to the actual billing for outpatients. (Based on his usual fees, Dr. Jones would have billed inpatients \$1,000 total for emergency services had his contract contained no restriction on billing.)

actual outpatient billings	=	\$22,000
assigned inpatient dollar value	=	<u>1,000</u>
<u>total billing value</u>	=	<u>\$23,000</u>

STEP 2: Deduct the total billing value from the contract guarantee to determine the amount of the unmet guarantee.

contract guarantee	=	\$25,000
total billing value	=	<u>-23,000</u>
<u>unmet guaranteed amount</u>	=	<u>\$ 2,000</u>

The Medicare portion of this unmet guaranteed amount would be reimbursed as reasonable costs under the Medicare program. If the contract does not require the physician to perform administrative and supervisory duties in any inpatient department, the unmet guaranteed amount would be recognized as a Part A and Part B cost in accordance with STEP 3 below.

STEP 3: Distribute the unmet guaranteed amount between Part A and Part B costs in the same ratio that emergency room and inpatient charges (real or assigned) bear to the total billing value.

Emergency room charges	=	\$22,000
Total billing value	=	<u>23,000</u> = 95 percent
Unmet guarantee	=	\$ 2,000
		<u>X .95</u>
Part B cost recognized	=	<u>\$ 1,900</u>

The remainder of the unmet guarantee, \$100, would be attributable to inpatient activities and would be recognized as a Part A cost.

NONPHYSICIAN ANESTHETISTS' SERVICES AS HOSPITAL SERVICES

When a nonphysician anesthetist (usually a nurse anesthetist) is a salaried member of the staff of a hospital, the services furnished by such an individual in connection with the administration of anesthetic agents are covered in the same manner as the services of other nonphysician hospital employees. Such services to hospital inpatients are covered under Part A as inpatient hospital services. When provided for outpatients, these services are covered under Part B as hospital services incident to a physician's services to outpatients. In either situation, reimbursement for the services furnished is made to the hospital on a reasonable cost basis.

When a nonphysician anesthetist who is not a salaried member of the hospital staff provides services to the hospital's inpatients on a fee-for-service basis, such services are covered in the same manner as the services of a salaried nonphysician anesthetist, provided the following conditions are met:

- (1) The nonphysician anesthetist must be contractually authorized to furnish such services; and
- (2) The services are made available under arrangements where payment to the hospital for the services discharges the liability of the patient or any other individual to pay for the services.

While the charges for equivalent services of the anesthetist must be uniform for Medicare and non-Medicare patients, billing practices of the nonphysician anesthetist need not be identical for both Medicare and non-Medicare patients. Anesthetist services provided "under arrangements" by which the hospital bills for the services will be reimbursed to the hospital on a reasonable cost basis. Services billed directly by a nonphysician anesthetist to an individual patient are not covered under Medicare but may be covered under other health plans or programs.

If a hospital imposes a charge for billing or other administrative services on a nonphysician anesthetist who is not a salaried member of the hospital staff and who is furnishing services "under arrangements", the amount of such charge is a discount from the cost of the services. It may not be treated as income by the hospital. Thus, the amount to be recognized as cost by the hospital is the net amount paid to the nonphysician anesthetist.

CHAPTER 23

PROVIDER-BASED PHYSICIANS

Reasonable Charges

Prevailing Charge

Fixed Compensation

Variable Compensation

Lease or Concession Arrangement

Relative Value Schedules

Duties and Responsibilities of
Provider and Intermediary in
the Area of Provider-Based
Physician Reimbursement

REIMBURSEMENT FOR SERVICES BY PROVIDER-BASED PHYSICIANS

Many providers employ or retain physicians on a full-time basis in the fields of pathology, physiatry, anesthesiology, radiology, and, in other fields of medical specialization. These physicians are often referred to as provider-based physicians. They may be engaged in a variety of activities including teaching, research, administration, supervision of professional or technical personnel, service on hospital committees, and other hospital-wide activities, as well as providing direct medical services to individual patients. The provider's arrangement may be with a single physician or with a group of physicians who assume joint responsibility for discharging agreed-upon duties.

Providers have a wide variety of arrangements for the compensation of provider-based physicians. Compensation may be in the form of salary or as a percentage of charges or of collections.

Payments may be made to the provider in its own right, or as an agent for the physicians, or payments may be made directly to the physicians. In other words, provider-based physicians may bill the patients directly or may arrange to have the provider bill the patients on their behalf. The Medicare program does not require any change in the substance of these arrangements.

Regardless of the method of distribution of the proceeds between the provider and the physicians, the charge to the patient was usually a single charge for each of the services. This created a problem for the Medicare program because of the two separate trust funds. You will remember that the Part A trust fund is used to reimburse provider services furnished to a beneficiary on a reasonable cost basis; the Part B trust fund is used to reimburse physicians and others for medical and surgical services to patients on a reasonable charge basis.

Because the payments are made from different trust funds, it is necessary to separate payments to provider-based physicians for administrative services under Part A from payments for professional services under Part B. Therefore, it is necessary, where billing is by or through the provider, to distinguish between the medical and surgical services rendered by a physician to a patient (the professional component) and the physician's services for the provider (the provider component).

The professional component of provider-based physician's services pertains to that part of the physician's activities which is directly related to the medical care of the individual patient. It represents compensation for the identifiable medical services by the physician which contribute to the diagnosis of the patient's condition or to his or her treatment.

The provider component represents that portion of the physician's services which is not directly related to an identifiable part of the medical care of the individual patient. Provider services include teaching, administration, general supervision of professional or technical personnel, laboratory quality control activities, committee work, performance of autopsies, and attending conferences as part of the physician's provider service activities. Reimbursement for such services are made on a reasonable cost basis under Part A where they relate to inpatient services. Reimbursement is under Part B for outpatient services and for certain inpatient ancillary services where Part A coverage has been exhausted.

Ordinarily, the compensation paid to the physician is for all services he performs, for his services to the provider as well as for direct patient services. In some institutions a physician may spend the greater part of his time in duties which benefit the entire patient population and a relatively small part of his time in performing services for individual patients. In other situations, the converse may exist. The allocation in each instance must be based on the facts of the individual case.

It is the obligation of the provider and provider-based physician to mutually agree upon the allocation of compensation for the provider-based physician based on the time he spends in his various activities, and to communicate this information with supporting material to the provider's intermediary. The supporting material should include a written explanation of the basis for the allocation agreement. (See Exhibit 1 at the end of this chapter.)

Under any of these arrangements, the agreement could stipulate that the physician may bill the patient through the provider for all or part of the services he renders, or that the physician and provider will bill separately for their respective services. It is necessary, therefore, to develop a schedule of charges for the services of the provider-based physician and to identify which elements of compensation are reimbursable under Part A and which are reimbursable under Part B.

This may be a good time to review how reasonable charges are determined under the Medicare program.

Reasonable charges for the professional services of provider-based physicians are determined by the Part B carrier in the same manner as these charges are determined for other physicians and suppliers. Consideration is given to the customary charges of the provider-based physician for each item of service he renders and to the prevailing charge in the locality for similar services rendered in a provider setting.

The Part B carrier uses the following criteria in determining reasonable charges, customary charges, prevailing charges and localities. (Of necessity, the description of these factors herein is brief and condensed. For more details, see Section 5000ff in the Medicare Carrier Manual, HIM-14.)

The two criteria set out in the Medicare law (Section 1842 of Title XVIII) which must be considered in determining the reasonable charge for a service are:

1. the customary charges for similar services generally made by the physician or other person furnishing such services; and
2. the prevailing charges in the locality for similar services.

Therefore, the reasonable charge for a specific service may not exceed the lowest of:

1. the physician's or other person's customary charge for that service;

2. the prevailing charge made for similar services in the locality;
or
3. the actual charge of the physician or other person rendering the service.

The income of the individual patient may not be considered in determining the amount of the reasonable charge. Consideration of a patient's income in determining the reasonable charge could be looked upon as an inverse means test; that is, it would result in a situation under which the Medicare program would pay more for beneficiaries with high incomes than it would pay for beneficiaries with low incomes. There is no provision in the Medicare law for a carrier to evaluate the reasonableness of charges in light of an individual beneficiary's economic status.

The Customary Charge

The customary charge is the amount which best represents the actual charges made for a given medical service by a physician to his patients in general, or by other persons who supply other medical and health services to the general public. The carrier therefore obtains information on the customary charges of physicians and other persons not only from the Medicare program, but from other available sources, e.g., from the carrier's own programs, from other insurance programs, from the Federal Employee Health Benefit Program, from any studies conducted by State or local medical societies, and from public agencies. It also may ask physicians or other persons for their charges for services rendered to the public in general where the carrier decides that circumstances justify the inquiry.

The Prevailing Charge

Prevailing charges are those charges which fall within the range of charges that are most frequently and widely used in a locality for a particular procedure or service. The top of this range establishes an overall limitation on the charges which the carrier should accept as reasonable for a given procedure or service, except where unusual circumstances or medical complications warrant an additional charge.

For any fiscal year, the prevailing charge limit in a locality for a service must be calculated as the 75th percentile of the customary charges determined for that service. In this calculation each customary charge for the service is arrayed in ascending order and weighted by how often the physician or other person rendered the service. (This information is reflected by the charge data the carrier used to calculate the customary charge.) The prevailing charge for the service is the lowest customary charge which is high enough to include the customary charges of the physicians or other persons who rendered 75 percent of the cumulative services.

Determination of Locality

For the purpose of making reasonable charge determinations, a locality is the geographic area for which the carrier is to derive the prevailing charges for services. Usually a locality will be a political or economic subdivision of a State, and it should include a cross-section of the population with respect to

economic and other characteristics. Where people tend to gravitate toward certain population centers to obtain medical care or service, localities may be recognized on a basis constituting medical service areas (interstate or otherwise), comparable in concept to "trade areas."

The principles in this chapter establishes a basis for determining the reasonable charges for physicians' services to patients where, under existing arrangements between providers and physicians, billings to patients have not separately identified the charges for physicians' services and the charges for hospital services.

The principles also establish a basis for determining the reasonable charges for a physician's services to patients in situations where there has been a change in the previously existing arrangement between the provider and the physician to permit the physician to bill patients separately for these services. (The provider will, of course, bill the patient separately for its own services.)

For Medicare purposes, there are three general classifications of arrangements made between providers and provider-based physicians. These are fixed compensation, variable compensation, or a lease or concession.

The fixed compensation, usually in the form of a salary or stipend, consists of a specific dollar amount which is not related to the volume of services rendered. The salary generally covers the physician's provider services as well as his direct medical services to patients.

Sometimes the fixed compensation is determined on the basis of a percentage of charges or collections reduced by bad debts or by other specific factors of operations. Such a contract should be treated as a fixed compensation contract.

Under a variable compensation arrangement, the provider and the physician agree that the physician's compensation will be a percentage of departmental gross charges or of net collections. There is no reduction for any bad debts or other factors of operations. The percentage of departmental gross charges or of net collections represents the provider's reimbursement to the physician for all services he or she renders. The actual compensation received by the physician will vary in proportion to the number of procedures performed and to the total charges made by the provider. The total compensation cannot be determined until the close of the accounting period. (See Exhibit II-A.)

Lease or Concession Arrangement

The physician enters into a lease or concession arrangement under which the physician assumes the cost of operating a department and bills the patients directly. The conditions for making the change are expressed in regulations, "...to bring about as little change as possible in the compensation the physician receives for his or her services in the hospital." Therefore, the customary charges for the physician's professional services should be related to his or her compensation before the change was made.

The customary charges of the physician should be based on:

- (1) the remuneration he/she received for his or her professional services to patients immediately prior to the leasing arrangement; and
- (2) his or her reasonable costs of operation, taking into account the provider's cost experience in providing such services.

It is necessary to refer to the remuneration formerly received by the hospital-based physician because such remuneration would be equivalent to the customary charges generally made by the physician for similar services, if the physician had no pattern of customary charges for his or her professional services to provider patients at the time the lease or other arrangement became effective. Where the provider has customarily identified a separate physician's charge for professional services, the physician's established charges are considered the customary charges for his or her professional services.

Where a provider initially pays some or all of the operating expenses of a department (e.g., salaries of nonprofessional personnel, supplies and equipment), such operating expenses are reimbursable as reasonable costs to the provider even though the provider is subsequently reimbursed by the physician.

Any payments received by the hospital under the above arrangement are treated as a reduction of allowable costs of the provider. The application of this offset is not limited to the allowable costs for a single department. If the Medicare portion of the income realized by a hospital exceeds the Medicare portion of allowable costs of such department, any remaining income must be applied as a reduction of Medicare reimbursable costs for the other departments of the hospital.

On the other hand, where a provider-based physician, him/herself, bears some or all of the costs of operation of a department, the costs which he or she bears may be reflected in his or her customary charges.

The difference in policy is based on whether the employees' salaries and other costs are direct obligations of the physician or of the provider. Where the costs are direct obligations of the provider, the physician is not permitted to assume the obligation through reimbursement to the provider.

Where, under an existing arrangement between a provider and physician, billings to patients have not separately identified charges for the physician's services and charges for provider services, a schedule of charges will need to be developed based on the physician's professional component. This schedule of charges will form the basis for establishing the customary charges for direct medical services to patients by the provider-based physician.

The schedule of charges must be designed to yield, in total, an amount equal to the portion of the physician's compensation represented by the professional component.

Also, where such contract changes permit the physician to independently bill Medicare patients only, the Part B carrier will ensure that the reasonable charges determined for the services rendered to Medicare beneficiaries are no

higher than the charges generally made to the provider's other patients for similar services.

The following are some elements which are considered in determining the amount of compensation received by a physician for the purpose of establishing a schedule of charges:

1. When fringe benefits inure to the benefit of the physician him/herself, they should be included as part of the physician's compensation. For example, group hospitalization and health insurance premiums paid or incurred by the provider for the benefit of the physician should be included in computing the physician's total compensation.

Where a provider established a retirement plan for the benefit of its employees and supplements employee contributions to the fund with specific amounts that are assignable to individual employees, such amounts should be included in ascertaining the physician's compensation.

2. Some providers have arrangements with medical schools or other organizations under which a physician receives compensation from such organizations for services which the physician renders to the provider patients. The remuneration of a physician from such sources should be included in determining that total compensation he/she receives and in establishing the schedule of charges. This remuneration must be allocated between the professional and provider activities of the provider in the same manner as the compensation received from the provider. That portion of remuneration related to teaching or research activities at the medical school itself is not reimbursable under Medicare.

3. Bad debts are not to be reflected in determining reasonable charges. The Medicare program reimburses 100 percent of the reasonable charges for inpatient hospital radiology and pathology services provided by a physician in the fields of radiology and pathology and 80 percent of the reasonable charges for all other medical services after the deductible has been met. The co-pay amount and the deductible are considered liabilities of the beneficiary for physicians' services, hence, the provider does not incur bad debts because of its failure to collect these amounts.

The amount of the physician's compensation representing the provider component is reimbursed to the provider on the basis of reasonable costs by Part A intermediary.

There are several methods by which a schedule of charges may be developed based on the provider-based physician's professional component. Principally, these are the optional, item-by-item and per diem methods. A variation from any of these methods is acceptable as long as it achieves the same result, i.e., it will yield in total an amount equivalent to the portion of a physician's compensation attributable to direct medical services to patients.

Each provider department may use the method it finds most applicable (e.g., the use of the item-by-item method by one department does not prevent the use of the optional method or the per diem method by another department). Where there is more than one hospital-based physician rendering services in a single department, the schedule of charges should be developed for the department as a whole on the basis of the total amount of compensation attributable to the professional components and the total volume of procedures which all physicians in the department are expected to render. (For establishing the professional component in a given department, see Exhibit II. To develop the schedule of charges, see Exhibits III, IV, and V.)

1. The optional method for establishing the physician's customary charges is appropriate for provider departments that perform a high volume of low cost procedures, often rendered by technicians or by automated equipment. Under the optional method, the schedule of charges for the physician's direct services to patients is determined by applying a uniform percentage to each charge made by a particular department. (See Exhibit III.)
2. The item by item method can be implemented by using an appropriate relative value schedule and conversion factor.

A relative value schedule (RVS) is based on assigning a numerical value to a medical or surgical procedure, relative to some basic procedure.

For example, a medical society appoints a panel of its members to study the problems of establishing some means of assisting its members in describing their services and in setting their fees. In the medical section (physician nonsurgical services) the panel chooses as the basic procedure to which all others in this section will be compared, the routine followup office visit and it assigns to this procedure the value of one. In making this determination, the physicians working on the relative value study apply a mixture of statistical data and professional judgment. Then, the time, skill and effort to make a comprehensive diagnostic history and examination is judged by the physician panel as being six times that which goes into a routine followup office visit. Thus, the relative value of a comprehensive diagnostic history and examination is six units.

In determining the amount of the fee, a physician multiplies the relative value units by a conversion factor. The conversion factor is a dollar amount, chosen on the basis of the economics of the physician's practice.

Example:

With a conversion factor of \$10, the fees for a routine followup office visit would be \$10. (1 RVS unit x \$10.)

The fee for a comprehensive diagnostic history and examination would be \$60. (6 RVS units x \$10.)

Generally, separate relative value schedules (RVS) are established for surgery, radiology, pathology, and other medical services. The RVS values assigned to the procedures in any one of these services are not correlated to the relative values of other services.

The Part B carrier must assure that the conversion factor assigned to unit values will result in reimbursement not in excess of the professional components of the hospital-based physician's compensation. (See Exhibits II and IV.)

The relative value study has several advantages not only for Medicare, but for other third party payers. These advantages are:

- A. The narrative descriptions of the various medical and surgical procedures provide a standard definition of these procedures enabling physicians to describe their services in a manner readily understandable by carriers,
- B. The numerical codes assigned to each procedure provide a readily usable description of the procedure for computer operations, and
- C. The relative value units when used with appropriate conversion factors provide a means for pricing services when gaps exist in the reasonable charge screens.

The first step in developing the data needed to establish the schedule of charges under the item-by-item method is to determine the amount of the provider-based physician's compensation attributable to direct patient services, reimbursable under Part B. (See Exhibit II.) The next step is to determine the total relative value units representing various procedures by particular provider departments. (See Exhibit IV.)

- 3. An alternate item-by-item method for establishing a schedule of charges on an item-by-item basis is to assign to each procedure, on the basis of the time spent by the physician in performing the procedure, a percentage of the total amount of the physician's compensation on a departmental basis. (See Exhibit V.)
- 4. The per diem method may be used where providers furnish health care services at an all-inclusive rate, or where there is no charge structure. It is most frequently applicable in long term or governmental facilities where both institutional and physician services are furnished at a fixed amount without regard to variations in the number and type of services the individual patient may receive and without distinction between the provider services and physician services furnished.

Some providers use the per diem or per visit method only in connection with the services of certain departments (e.g., psychiatry outpatient) while charging on a fee-for-services basis in others.

Establishing a schedule of charges through the per diem or per visit method is limited to institutions or departments which make an identifiable uniform charge that constitutes the total expense the patient incurs for both provider and physician services. (See Exhibit VI.)

There have been times when physicians who have been employed by providers to perform both administrative services and direct medical care services have terminated their employment relationship with the providers. The physicians have then formed a new organization which enters into an arrangement with the providers to render only administrative services and teaching services, usually at a higher cost for these services than was formerly received in the employment relationship. These organizations bill patients directly for patient care services of their member physicians. Such billings often exceed the estimated portion of the previous salary attributable to such services.

Where a provider which previously employed physicians on a salary basis to render administrative and/or teaching services as well as direct medical care services changes its arrangement to purchase only the administrative and/or teaching type services, program reimbursement to the provider would be limited to the cost previously incurred for such administrative and/or teaching services on a salary basis.

An exception to such limitation may be granted where the provider demonstrates that, due to extraordinary circumstances, it is no longer able to engage physicians at the previous level of compensation to render the full range of services. Merely showing that the physicians previously employed were no longer willing to provide their services on this basis would not demonstrate that the provider is no longer able to engage physicians at the previous level of compensation. For the new financial arrangement to be accepted by the intermediary as reasonable costs, the provider would also have to demonstrate that, due to some new and special circumstances, it was no longer feasible to recruit replacements at the previous level of compensation to render the full range of services.

Reasonable charges for the physicians' direct patient care services should initially be related as closely as possible to the portion of the compensation they receive for such services prior to the change in the financial arrangement. These charges are subject to any applicable prevailing charge ceiling and will serve as the basis for program payment until:

- (1) The physician has established a pattern of customary charges which are billed to all patients and collected from the majority of his non-Medicare patients, and
- (2) The carrier has accumulated at least three months of charge data from the same base year used to establish reasonable charges for other physicians.

When these criteria are met, the physician's reasonable charge will be determined in the same manner as other fee-for-service physicians. (Where a group of physicians uses a common schedule of charges, reasonable charges should be determined in this manner for the group.)

Where a provider-based physician agrees with the provider (whether in writing, orally, or in any way implied) to receive a reduced compensation or to remit a portion of his/her gross compensation back to the provider, only the net amount received and retained by the physician represents the total compensation for both provider services and professional medical and surgical services. The net amount is the amount to be used in computing Medicare reimbursement to the provider. The Medicare program does not intend for a provider to be reimbursed on a basis of gross compensation while effectively paying out a lesser amount.

As an exception, a bona fide, voluntary contribution made by a physician to the provider is not a reduction of the physician's compensation for the purpose of computing Medicare reimbursement to the provider. The bona fide nature of the contribution must be established on the basis of all circumstances surrounding the contribution.

EXAMPLE: A contract provides that a provider-based pathologist will receive 30 percent of gross departmental charges less 5 percent of the gross charges for bad debts and courtesy allowances. During the provider's Medicare cost reporting period, the department had \$200,000 in gross charges. The provider retains \$6,000 of the pathologist's compensation for the physicians' pension fund. Of the amount received from the provider, the pathologist agreed to return \$4,000 (\$2,000 for the provider's equipment fund and \$2,000 to be used for general purposes). In addition, the intermediary verified that the pathologist made a bona fide, voluntary contribution of \$5,000 to the provider.

Calculation of Physician's Compensation to be Used in Computing Medicare Reimbursement to the Provider:

- Compensation received by the pathologist, including the \$6,000 retained by the provider for the sole benefit of the pathologist (\$200,000 in gross departmental charges x 25 percent (30 percent of gross departmental charges less 5 percent of the gross charges for bad debts and courtesy)).	\$50,000
Less - amount returned to provider by agreement for restricted fund of provider.	<u>2,000</u>
	\$48,000
Less - amount returned to provider by agreement for unrestricted use of provider.	<u>2,000</u>
- Net amount received and retained by the pathologist to be used in computing the provider's Medicare reimbursement (to be further distinguished as to the amount representing professional medical and surgical services and the amount representing provider services).	<u>\$46,000</u>

The amount of the bona fide, voluntary contribution (\$5,000) is not deducted from the pathologist's compensation for the purpose of computing Medicare reimbursement to the provider.

Where direct medical services are rendered by a physician to nonprovider patients, all direct and indirect provider costs incurred by the provider in connection with the provision of such services should be identified and deducted from provider costs in arriving at allowable costs for Medicare purposes. Where the costs for rendering these services cannot be identified, reasonable estimates must be made of the costs incurred by the provider. Where the provider receives revenue that is related to such services, such estimated costs may not be less than such revenue.

Duties and Responsibilities of Provider and Intermediary in the Area of Provider-Based Physician Reimbursement

1. Provider Responsibility

The effective implementation of provider-based physician reimbursement requires the closest coordination between the provider and its Part A intermediary. The provider is responsible for making available on a timely basis data on the financial and billing arrangements (including contracts, agreements, and other written documentation) it has with its provider-based physicians. This information is necessary to ensure that:

- (A) Medicare reimbursement for the services of these physicians is made from the appropriate trust funds,
- (B) The Medicare program does not make duplicate payments for the same service, once as a provider cost and again as a reasonable charge, and
- (C) The Part B reasonable charge properly reflects any deductible and co-pay liability of the beneficiary.

2. Intermediary Responsibility

The Part A intermediary will obtain from the provider not only all data needed to determine reimbursable hospital costs, but also the data needed by the Part B carrier for establishing and reviewing the schedules of charges it will use to make reasonable charge determinations.

Exhibits - Provider-Based Physicians

The following exhibits are taken from Section 2108.11 in the Provider Reimbursement Manual (PRM)

- Exhibit I - Hospital-Based Physician Allocation Agreement
- Exhibit II - Determination of Amount of Provider-Based Physician Compensation Reimbursable Under Part B

Exhibit IIA - Determination of Uniform Optional Percentage

Exhibit III - The Uniform Optional Percentage

Exhibit IV - Item-by-Item Method - Relative Value Schedule

Exhibit V - Alternate Item-by-Item Method

Exhibit VI - Per Diem or Per Visit Method

Exhibit VII - Calculation of Reimbursement Settlement for Professional Services Rendered to Medicare Beneficiaries by Provider-Based Physicians Not Using Combined Billing

EXHIBIT I

HOSPITAL-BASED PHYSICIAN ALLOCATION AGREEMENT

The following schedule represents the distribution of time and activities of the physicians in the _____ department:

<u>1. Activity, other than direct patient services</u>	<u>Percent of Time</u>
(a) Teaching	5
(b) Research (including attendance at lectures, etc.)	10
(c) Administration	10
(d) Supervision of technical and other personnel	20
(e) Hospital services (committees, etc.)	5
(f) Services of general benefit to patients (quality control, etc.)	<u>25</u>
Total	75

2. Activity, direct personal services to individual patients

The allocation of time by activity as shown above was based on
(select one of the following):

1. Time study 2. Estimate 3. Other (attach explanation)

Signed _____ Administrator of Provider

Signed _____ Physician(s)

EXHIBIT II

DETERMINATION OF AMOUNT OF PROVIDER-BASED PHYSICIAN COMPENSATION

REIMBURSABLE UNDER PART B

1	2	3	4	5	6
Department	Physicians	Compensation	Professional Component Allocation	Part B Amount	Approved Carrier Intermedia
PATHOLOGY	SMITH	\$22,000	20%	\$ 4,400	
	JONES	20,000	25%	5,000	
	GREEN	18,000	30%	<u>5,400</u>	
				\$14,800	

The method for determining the Part B component of the physician's compensation is demonstrated in Exhibit II. The data in each of the columns is as follows:

- Column 1 - DEPARTMENT - Indicate a single provider department with one or more provider-based physicians rendering a significant volume of professional services to Medicare beneficiaries.
- Column 2 - PHYSICIANS - List the name of each physician in this department rendering direct patient services.
- Column 3 - COMPENSATION - Show the annual remuneration for each physician receiving a fixed compensation. (Where a physician changed to direct billing subsequent to June 30, 1966, the compensation amount for the year prior to the change should be obtained and used.)
- Column 4 - PROFESSIONAL COMPONENT ALLOCATION - List the percentage of compensation attributable to direct patient services.
- Column 5 - PART B AMOUNT - Multiply Column 3 (Compensation) by Column 4 (Professional Component Allocation) to obtain the portion of each physician's salary attributable to Part B services.
- Column 6 - APPROVED - By initialing and dating their action, the intermediary and carrier show approval of the determination.

EXHIBIT II A

DETERMINATION OF UNIFORM OPTIONAL PERCENTAGE

(Compensation Arrangement Stipulates Percentage of
Gross Charges or Collections)

1	2	3	4	5	6	
Department	Physicians	Contract Percentage	Professional Component Allocation	Uniform Optional Percentage	Approved Carrier	Inter- mediary
PATHOLOGY	SMITH	35%	20	7.0%		

Where a physician has a variable compensation arrangement and wishes to use the uniform optional percentage, enter the appropriate data in the columns of Exhibit II A as follows:

- Column 1 - DEPARTMENT - Indicate a single provider department with one or more provider-based physicians rendering a significant volume of professional services to Medicare beneficiaries.
- Column 2 - PHYSICIANS - List the name of each physician in this department rendering direct patient services.
- Column 3 - CONTRACT PERCENTAGE - Show the contract percentage.
- Column 4 - PROFESSIONAL COMPONENT ALLOCATION - List the percentage of compensation attributable to direct patient services.
- Column 5 - UNIFORM OPTIONAL PERCENTAGE - Multiply Column 3 (Contract Percentage) by Column 4 (Professional Component Allocation) for each physician. This amount (rounded to the nearest one-half percent) is the uniform optional percentage. The physicians' Part B charge for each service is derived by applying this uniform optional percentage to the provider's established charge for each service.
- Column 6 - APPROVED - By initialing and dating their action, the intermediary and carrier show approval of the determination.

EXHIBIT III

THE UNIFORM OPTIONAL PERCENTAGE

1	2	3	4	5	
Department	Part B Amount	Estimated Gross Department Charges	Uniform Optional Percentage	Approved Carrier	Approved Intermediary
PATHOLOGY	\$14,800	\$200,000	7.4%		

After completing Exhibit II, where a physician has a fixed compensation and desires to use the uniform optional percentage, enter additional data in the appropriate columns of Exhibit III as follows:

- Column 1 - DEPARTMENT - Show one provider department with provider-based physicians who render identifiable direct patient services.
- Column 2 - PART B AMOUNT - The Part B amount was derived in Exhibit II, Column 5. Enter that amount in this column.
- Column 3 - ESTIMATED GROSS DEPARTMENT CHARGES - Enter the estimated gross departmental charges for the year.
- Column 4 - UNIFORM OPTIONAL PERCENTAGE - Divide Column 2 (Part B Amount) by Column 3 (Estimated Gross Department Charges) to obtain the uniform optional percentage. This percentage is applied to all departmental billings, and will yield in the aggregate an amount equal to the Part B Amount (Column 2). (This percentage may be rounded where such action will not result in reimbursement of an amount appreciably different from the amount in Column 2.)
- Column 5 - APPROVED - By initialing and dating their action, the intermediary and carrier indicate approval of the determination.

EXHIBIT IV

ITEM-BY-ITEM METHOD - RELATIVE VALUE SCHEDULE

1	2	3	4	5	
Department	Part B Amount	Estimated Gross Department Charges	Uniform Optional Percentage	Approved Carrier	Intermediary
PATHOLOGY	\$14,800	\$200,000	7.4%		

After completion of Exhibit II, in order to determine the Part B charge for the various procedures performed in a provider department, enter the appropriate data in the column of Exhibit IV as follows:

- Column 1 - PROCEDURE - List each procedure with significant physician involvement performed in the provider department.
- Column 2 - PROVIDER'S ESTABLISHED CHARGE - Show the provider's charge for each procedure shown in Column 1.
- Column 3 - PERCENT - PHYSICIAN'S SERVICE - For each procedure show the percentage which represents the extent of physician involvement in rendering direct patient services. (Examples: For procedure "U" it is estimated that 50 percent of the provider charge represents physician involvement each time the procedure is performed. For procedure "V" physician involvement is negligible and the procedure is not used in obtaining the Part B charge.)
- Column 4 - RELATIVE NUMERICAL VALUE - Multiply Column 2 (Provider's Established Charge) by Column 3 (Percent - Physician's Service) to obtain the Relative Numerical Value.
- Column 5 - ESTIMATED ANNUAL PROCEDURES - Show the estimated number of times each procedure will be rendered during the year.
- Column 6 - TOTAL UNITS - The total relative value units for each procedure represent the estimated aggregate value of the physician component for each procedure and are obtained by multiplying Column

4 (Relative Numerical Value) by Column 5 (Estimated Procedures - Annual). The total units for each procedure are added to obtain the aggregate number of units for the department.

- Column 7 - CONVERSION FACTOR - Divide the Part B Amount (Exhibit II, Column 5) by the aggregate number of units, Column 6 (Total Units). (Round the answer to the nearest tenth.)
- Column 8 - PART B CHARGE - Multiply Column 7 (Conversion Factor) by Column 4 (Relative Numerical Value) to obtain the Part B component charge for each procedure.
- Column 9 - APPROVED - By initiating and dating their action, the intermediary and carrier indicate approval of the determination.

Note: If an existing relative value schedule is to be used, complete Column 1, and omit Columns 2 and 3. Enter in Column 4 the appropriate relative numerical value for each procedure as indicated in the existing relative value schedule. Complete Columns 5 through 7 as described in the instructions for Exhibit IV.

EXHIBIT V

ALTERNATE ITEM-BY-ITEM METHOD

1	2	PATHOLOGY (DEPARTMENT)		5	6	
		3	4			
Procedure	Professional Component Percentage	Part B Compensation	Estimated Procedures (Annual)	Part B Component Charges	Approved Carrier	Intermediary
M	15%	\$ 2,220	1,100	\$ 2.00		
N	10	1,480	200	7.50		
O	5	740	55	13.50		
P	20	2,960	300	10.00		
Q	25	3,700	1,700	2.00		
R	5	740	100	7.50		
S	10	1,480	150	10.00		
T	10	1,480	200	7.50		
	(100%)					
		\$14,800				

After completing Exhibit II, where the physicians in a single provider department elect to use the alternate item-by-item method, enter the following data in the appropriate columns:

- Column 1 - PROCEDURE - List each procedure performed in the department with significant physician involvement.
- Column 2 - PROFESSIONAL COMPONENT PERCENTAGE - Show the percentage of time which the physicians collectively spend performing each procedure. (The total time spent should equal 100 percent of the time devoted to direct patient services.)
- Column 3 - PART B COMPENSATION - Multiply the amount shown in Exhibit II, Column 5, by each percentage in Column 2.
- Column 4 - ESTIMATED ANNUAL PROCEDURES - Estimate the number of times each procedure will be performed in the coming year.
- Column 5 - PART B COMPONENT CHARGES - The physician Part B charge is derived by dividing Column 3 (Part B Compensation by Column 4 - Estimated Procedures - Annual) rounded to nearest 50 cents.
- Column 6 - APPROVED - By initialing and dating their action, the intermediary and carrier indicate approval of the determination.

EXHIBIT VI

PER DIEM OR PER VISIT METHOD

THE METHOD - TABLE A

1	2	3				4	
Department	Total Physician Compensation	Division of Compensation				Inpatient Compensation for Direct Patient Services	
		Outpatient		Inpatient			
Radiology	\$52,000	50%	\$26,000	50%	\$26,000	60%	\$15,600
Pathology	40,000	35	14,000	65	26,000	40	10,400
Anesthesiology	42,000	10	4,200	90	37,800	85	32,130
Internal Med.	150,000	35	52,500	65	97,500	90	87,750
Surgery	155,000	30	46,500	70	108,500	90	97,650
		Total - \$143,200				Total - \$243,530	

INPATIENT RATE - TABLE B

	2	3	4	5
Direct Patient Service Dept.	Part B Amount	Inpatient Days	Per Diem Rate	Approved Carrier Intermediary
HOSPITAL RADIOLOGY	\$26,000	100,000	(26) 25	
HOSPITAL PATHOLOGY				
ALL OTHER DEPARTMENTS	217,530	100,000	(218) 220	
ALL OTHER PROVIDER SETTINGS				
ALL DEPTS.	243,530	100,000	(244) 245	

OUTPATIENT RATE - TABLE C

	Direct Patient Service Dept.	Part B Amount	Outpatient Visits	Per Visit Rate	Approved Carrier Intermediary
ALL PROVIDER SETTINGS	ALL DEPTS.	\$143,200	41,000	(349) 350	

EXHIBIT VI (Cont.)

In developing the per diem (or per visit) method of reimbursement, enter the pertinent information in the appropriate columns in Exhibit VI. Separate tables are presented to show the basic data necessary (Table A) and its utilization in deriving the inpatient rate (Table B) and the outpatient rate (Table C).

Under this method, only compensation paid to physicians who normally render services to Medicare patients should be included in the computation. Thus, the compensation of obstetricians, pediatricians, and other physicians who do not normally render services to Medicare beneficiaries should not be included. In addition, the patient days attributed to the departments of the institution which do not usually provide services for Medicare patients should also be excluded from the per diem computation.

It should also be noted that some physicians who render services to Medicare patients also render services that are not covered under the program. For example, dentists and podiatrists provide covered services as well as non-covered services to beneficiaries. In such cases, the physicians' compensation allocated to those noncovered services should be omitted from the per diem computation.

<u>Table A</u>	<u>The Method</u>
Column 1	DEPARTMENT - List each provider department in which a significant number of services for Medicare patients are rendered.
Column 2	TOTAL PHYSICIAN COMPENSATION - On a departmental basis show the total physician compensation.
Column 3	DIVISION OF COMPENSATION - On a departmental basis show the percentage and amount of the total physician compensation (Column 1) attributable to outpatient and inpatient services, and enter the aggregate total for outpatient services in the space provided in Column 3.
Column 4	INPATIENT - COMPENSATION FOR DIRECT PATIENT SERVICES - Of the inpatient compensation (Column 3) show the percentage and amount attributable to direct patient services to inpatients. Enter the aggregate total compensation attributable to inpatient direct patient services in the space provided in Column 4.

EXHIBIT VI (Cont.)

Table B

The Inpatient Rate

Column 1	DIRECT PATIENT SERVICES - DEPARTMENT - In the hospital setting it is necessary to separate the radiology and pathology department compensation from other compensation because the direct patient services of these specialty departments are reimbursable without application of the coinsurance and deductible provisions. In other provider settings, all departments are considered together.
Column 2	PART B AMOUNT - This item corresponds to the total of Table A, Column 4. In the hospital setting the amount attributable to the radiology and pathology departments must be shown separately.
Column 3	INPATIENT DAYS - Indicate the estimated total number of inpatient days for the year.
Column 4	PER DIEM RATE - The rate is obtained by dividing Column 2 (Part B Amount) by Column 3 (Inpatient Days) and rounding to the nearest multiple of \$.05.
Column 5	APPROVED - The carrier and intermediary will signify their approval of the determination by initialing and dating their action.

EXHIBIT VI (Cont.)

Table C

The Outpatient Rate

Column 1	DIRECT PATIENT SERVICES - DEPARTMENT - No differentiation among departments is necessary.
Column 2	PART B AMOUNT - This item corresponds to the total of Table A, Column 3 (Outpatient).
Column 3	OUTPATIENT VISITS - Indicate the estimated total number of outpatient visits for the year.
Column 4	PER VISIT RATE - Divide Column 2 (Part B Amount) by Column 3 (Outpatient Visits) and round to the nearest multiple of \$.05.
Column 5	APPROVED - The carrier and intermediary will signify their approval of the determination by initialing and dating their action.

EXHIBIT VII

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR PROFESSIONAL SERVICES RENDERED TO MEDICARE BENEFICIARIES BY PROVIDER-BASED PHYSICIANS NOT USING COMBINED BILLING		Period:		Provider		
		Carrier		Carrier		
		Name:		No.		
		Intermediary		Intermediary		
		Name:		No.		
PART I - Apportionment of Total Remuneration to Medicare						
Physician Department:		A	B	C	D	E
		1. Total Charges (All Patients)	1. Program Charges	Ratio of Program Charges to Total Charges	Total Remuneration Applicable to Professional Services	Program Professional Services Remuneration (C x D)
1. Radiology - Inpatient Services		\$	\$	%	\$	\$
2. Pathology - Inpatient Services						
3. Total (Sum of Lines 1 and 2)		\$	\$	%	\$	\$
B. ALL OTHER PROFESSIONAL SERVICES:						
4. Radiology - Outpatient Services		\$	\$	%	\$	\$
5. Pathology - Outpatient Services						
6. Other (Specify)						
7. Other (Specify)						
8. Other (Specify)						
9. Other (Specify)						
10. Other (Specify)						
11. Total (Sum of Lines 4 thru 10)		\$	\$	%	\$	\$

PART II - Calculation of Amount Due Provider/Medicare	
12. Program Remuneration for Professional Services (Excluding Radiology and Pathology - Inpatient Services) (Line 11 Column E).	\$
13. 80% x Line 12	\$
14. Add: Program Remuneration Applicable to Professional Radiology and Pathology - Inpatient Services (Line 3 Column E).	\$
15. Total Program Professional Services Remuneration Subject to Retroactive Adjustment (Line 13 Plus 14). ²	\$
16. From Provider's Records: Program Physician Component Charges Applicable to Professional Services (Excluding Radiology and Pathology - Inpatient Services) (Line 11 Column B). (If Combined Charges are Used in Column B, Then the Portion of the Combined Charges That Represent the Physician Professional Component Must be Used Here.)	\$
17. 80% x Line 16	\$
18. Add: Program Physician Component Charges Applicable to Professional Radiology and Pathology - Inpatient Services (Line 3 Column B). (If Combined Charges are Used in Column B, Then the Portion of the Combined Charges That Represent the Physician Professional Component Must be Used Here.)	\$
19. Total Program Physician Component Charges Subject to Retroactive Adjustment (Sum of Lines 17 and 18).	\$
20. Balance Due Provider/Medicare (Difference Between Lines 15 and 19). This Amount is to be Paid by or Returned to the Intermediary	\$

¹If gross combined charges for professional and provider components are used in Column A, then combined charges must be used in Column B. If gross charges for professional component only are used in Column A, then gross charges for professional component only must be used in Column B.

²The "Total Program Professional Services Remuneration Subject to Retroactive Adjustment" (Line 15) and the "Total Program Physician Component Charges Subject to Retroactive Adjustment" (Line 19) have been computed without considering the deductibles billed to program patients. Such deductibles apply equally to the "Program Professional Services Remuneration" and to the "Program Physician Component Charges."

CHAPTER 24

TEACHING HOSPITALS AND TEACHING PHYSICIANS

Intermediary Letter No. 372

Teaching Hospitals and Teaching Physicians

This chapter deals with reimbursement for physicians' services rendered in a teaching hospital by physicians on the hospital staff. It also describes reimbursement for services rendered in a teaching hospital by the faculty of a medical school or organization related thereto.

Background

There are about 1,400 "teaching hospitals" in the country, most of which are organizationally, and often physically, associated with medical schools. In these hospitals, interns and residents receive training in the delivery of medical care to patients under the supervision of teaching physicians.

In non-teaching hospitals, physician services are usually delivered by an individual physician to an individual patient. In teaching hospitals, however, a team of interns and residents and attending physicians care for patients, in the course of which the interns and residents receive their education and training. (Note: Interns and residents are referred to as "house officers" in some hospitals.)

The teaching physician provides graduate medical education and patient care in the teaching hospital. The teaching physician is a fully trained physician who is responsible for, or is directly engaged in, patient care activities and is also responsible for the instruction and supervision of interns and residents. (Note: The term "physician" does not include any resident or intern of the hospital regardless of any other title by which he is designated or his position on the medical staff. For example, a senior resident who is referred to as an "assistant attending surgeon" or an "associate physician" would still be considered a resident.)

Compensation arrangements between teaching physicians and hospitals and medical schools vary. Many teaching physicians are employees of these institutions; others have contractual agreements covering specific services or time; still others have no financial arrangements with any institution. It is not uncommon for a teaching physician to have financial arrangements with more than one institution.

Hospitals which receive reimbursement for physician services on a cost basis (or a compensation-related basis) have sole control over these revenues and usually include them as part of their general patient care revenues. In these hospitals, the physicians are direct employees of the hospital or are under contract for patient care services.

In some cases, the hospital receives and controls professional fees under a fee-based method of payment. The hospital bills and collects for professional services carried out by the physician group and pays out part of these revenues for physician salaries.

In other hospitals, fees for the professional services of teaching physicians are received and expended by a faculty practice plan which operates under the auspices of the medical school. For the most part, these revenues are used to support clinical faculty salaries, with small amounts going to support other institutional activities, such as basic science and graduate medical education.

The compensation of interns and residents is principally by salary from the hospital, medical school, or both. In a majority of hospitals, intern and resident salaries came from general patient care revenues. In some hospitals, salaries came from State or local appropriations to the hospitals or medical schools.

Patients are often classified by the hospitals according to whether they are "private patients" or "nonprivate patients." A private patient is one who has had a doctor-patient relationship with the attending physician prior to admission. The nonprivate patient had no prior relationship with any of the physicians prior to admission.

Patient classification is a factor in the extent of an intern's or resident's responsibility for patient care and the amount of supervision he receives. Interns and residents usually have more responsibility and less supervision by teaching physicians when they are taking care of nonprivate patients than they do with private patients.

Medicare Payments for Teaching Physicians

Given all of these complexities and interrelationships, it is no wonder that the Medicare program has had problems with the methods of payment for physician services in teaching hospitals since the beginning of the program. As you know, the Medicare payment structure is based on separate billing by the hospital and by the patient's physician. Part A of Medicare, the hospital insurance program, pays hospital costs, including salaries of interns and residents and supervisory physicians participating in education programs in the hospital. Part B of Medicare, the supplementary medical insurance program, pays for the services of the physician who is responsible for the care and medical decisions concerning any individual patient.

However, in teaching hospitals the actual services and responsibilities of the physicians do not necessarily correspond to the distinctions implied by Part A and Part B of Medicare. Teaching and patient care are inseparably commingled. Responsibility for the patient, medically if not legally, becomes shared among the teachers and learners. Because a great deal of patient care in a teaching hospital is provided by interns and residents whose salaries are paid under Part A of Medicare, a major question was under what circumstances was it reasonable to pay a professional fee to a teaching physician?

In 1969, Medicare issued Intermediary Letter No. 372 which spelled out a policy for paying teaching physicians for medical services to Medicare patients. (An Intermediary Letter (IL) is an informational letter issued by Medicare to intermediaries describing a Medicare problem and some possible solutions.)

IL 372 permitted a teaching physician to make a charge for identifiable, personal medical services to a patient or for the direct supervision of such services by interns and residents if the teaching physician met the criteria established in IL 372 for determining if he was the "attending physician." (See copy of IL 372 at the end of this chapter)

The criteria required that:

1. the physician must render sufficient personal and identifiable medical services to the Medicare patient to exercise full, personal control over the management of the portion of the case for which a charge can be recognized,
2. his services to the patient must be of the same character, in terms of responsibilities to the patient, as the services he renders to his other paying patients.

The teaching physician must, as a minimum:

1. review the patient's history, the record of examinations and tests in the institution, and make frequent reviews of the patient's progress,
2. personally examine the patient,
3. confirm or revise the diagnosis and determine the course of treatment to be followed,
4. either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by interns, residents, or others and that the care meets a proper quality level,
5. be present and ready to perform any service performed by an attending physician in a nonteaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed; the physician's presence as an attending physician must be necessary (not superfluous as where, for example, the resident performing the procedure is fully qualified to do so), and
6. be recognized by the patient as his personal physician and be personally responsible for the continuity of the patient's care, at least throughout the period of hospitalization.

If the teaching physician cannot meet these tests, it is assumed that the care is rendered by the interns and residents and is fully reimbursed under Part A, and that the teaching physician's role is that of the teacher and supervisor rather than personal physician.

In 1972, the 1972 Amendments contained a Section, 227, which attempted to simplify the payment problem by establishing presumptions which would classify hospitals in their entirety as:

1. hospitals in which the hospital or the physician could bill for professional fees, or

2. hospitals which must be paid on a cost basis for professional services.

In other situations, Section 227 allowed physicians to bill on a fee basis for services to patients with whom they had a prior professional relationship.

But before Section 227 was implemented, the Social Security Amendments of the following year, 1973, requested that a study be made of the Medicare payment system for physician services in teaching hospitals. Pending completion of the study, Section 227 was suspended. (The study was made by the Institute of Medicine of the National Academy of Sciences and was completed in 1976.)

After a review of the study, and based on its own experience with reimbursement for teaching physicians, HCFA has proposed some changes in the reimbursement policies, but the proposed changes have not yet been implemented. Therefore, reimbursement for teaching physicians is currently based on the policies contained in IL 372 and in some segments of Section 227 of the 1972 Amendments.

Reimbursement under IL 372 has been described above. Other methods of reimbursement for teaching physicians currently in use include:

1. Reimbursement on a reasonable cost basis where the teaching hospital has so elected.
2. Salary equivalency payments for volunteer direct medical and surgical services in the care of individual patients.

These methods are described below.

Election to Receive Medicare Reimbursement on a Reasonable Cost Basis

For cost reporting periods beginning after June 30, 1973, a teaching hospital may elect to receive reimbursement on a reasonable cost basis for the direct medical and surgical services of its physicians in lieu of any payment on the basis of reasonable charges which might otherwise be payable for such services.

A hospital may make this election to receive cost reimbursement only where all physicians who render services in the hospital which are covered under the Medicare program agree in writing not to bill charges for such services (or where all the physicians are employees of the hospital and as a condition of employment they are precluded from billing for such services.)

Where the hospital elects to receive Medicare reimbursement on a reasonable cost basis, the physicians on the hospital staff will be reimbursed as a provider service on a reasonable cost basis for:

1. direct medical and surgical services rendered to Medicare patients,
2. supervision of interns and residents in the care of individual patients.

Likewise, reimbursement will be made to the hospital for the reasonable costs incurred by a medical school or organization related to the hospital for direct medical and surgical services, including supervision of interns and residents in the care of individual patients.

These services are covered under Part A when rendered to inpatients and are covered under Part B when rendered to outpatients.

Reasonable costs incurred by a teaching hospital in compensating physicians for direct medical and surgical services to patients, including supervision of interns and residents in the care of individual patients, are not subject to cost finding as described in PRM Chapter 23. Rather, these costs are separately accumulated and apportioned in accordance with the Aggregate Per Diem Method of apportionment (See Section 2218 in PRM). For purposes of this section, "reasonable costs" is defined as the direct salary paid to such physicians plus applicable fringe benefits.

Reasonable costs incurred by a teaching hospital for direct medical and surgical services rendered by a medical school (or organization related to the medical school) in the hospital are reimbursable to the hospital by the program, provided that such costs would be reimbursable if incurred directly by the hospital rather than under such arrangement. In situations where the medical school and the hospital are related by common ownership or control in accordance with PRM Chapter 10, the costs of such services are allowable costs to the hospital under the provisions of that chapter.

The allowable costs to the medical school or organization related thereto include the physicians' direct salaries, applicable fringe benefits, employer's portion of FICA taxes, Federal and State unemployment taxes, and workmen's compensation. Such costs are subject to substantiation by the hospital with appropriate documentation showing that these costs are related to the rendition of patient care services in the hospital.

(See Section 2218 in the Provider Reimbursement Manual (PRM) for more detailed descriptions and examples of aggregate per diem methods of apportionment for physicians' direct medical and surgical services rendered in a teaching hospital in the care of individual patients, including supervision of interns and residents rendering such services.)

There are some definitions related to teaching hospitals and teaching physicians with which you should become familiar.

The imputed value of physicians' direct medical and surgical services, including supervision of interns and residents in the care of individual patients, rendered in a teaching hospital to Medicare patients is determined on the basis of an average per diem derived from the imputed value of physicians' volunteer direct medical and surgical services rendered to all patients.

Average cost per diem for physicians' direct medical and surgical services, including supervision of interns and residents in the care of individual patients means the amount computed by dividing total reasonable costs of such services in each category by the sum of:

1. Inpatient days (as defined below), plus

2. Outpatient visit days (as defined below).

Inpatient Days -- Inpatient days are determined by counting the day of admission as 3.5 days and each day subsequent to a patient's day of admission, omitting the day of discharge, as one day. (This 3.5 weighting factor recognizes the intensity of physicians' services on the day of admission.)

Outpatient Visit Days -- Outpatient visit days will be determined by counting one visit day for each calendar day that a patient visits the outpatient department.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

HI:PS:H

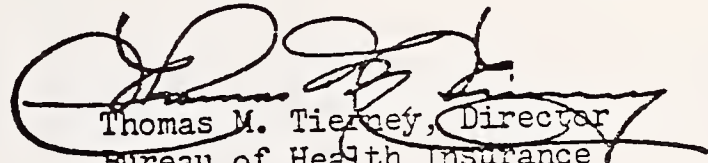
April 1969

BUREAU OF HEALTH INSURANCE
INTERMEDIARY LETTER NO. 372

SUBJECT: Part B payments for services of supervising physicians in a
teaching setting

From questions which have been raised and from our onsite reviews, there appears to be a serious need to obtain a better and more uniform understanding among carriers, providers, and physicians of the conditions under which payment may be made under Part B for services rendered to patients by supervising physicians in the teaching setting and the method for determining the reasonable charge which may be recognized for such services. The enclosed guidelines are intended to clarify and supplement the criteria that govern reimbursement in this area as reflected in SS6102.7, 6335, and 6720 ff. of the Part B Intermediary Manual.

Carriers are urged to review their present reimbursement practices in light of these guidelines and to take appropriate action as soon as possible to bring practices into conformity with the guidelines. The Part B Intermediary Manual will be revised to incorporate these clarifications and additions.


Thomas M. Tierney, Director
Bureau of Health Insurance

Enclosure

Part B Payments for Services of
Supervising Physicians in a Teaching Setting

A. Conditions Which Must be Met for a Teaching Physician to be Eligible for
Part B Reimbursement as an Attending Physician

*
The physician must be the patient's "attending physician." This means he must, as demonstrated by performance of the activities listed below, render sufficient personal and identifiable medical services to the Medicare beneficiary to exercise full, personal control over the management of the portion of the case for which a charge can be recognized; his/her service to the patient must be of the same character, in terms of the responsibilities to the patient that are assumed and fulfilled, as the services he/she renders to his/her other paying patients.

1. To be the "attending physician" for an entire period of hospital care, the teaching physician must be as a minimum:
 - a. review the patient's history, the record of examinations and tests in the institution, and make frequent reviews of the patient's progress, and
 - b. personally examine the patient, and
 - c. confirm or revise the diagnosis and determine the course of treatment to be followed, and
 - d. either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by interns, residents, or others and that the care meets a proper quality level, and
 - e. be present and ready to perform any service performed by an attending physician in a nonteaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed; for the physician to be an "attending physician" his/her presence as an attending physician must be necessary (not superfluous as where, for example, the resident performing the procedure is fully qualified to do so) from the medical standpoint, and
 - f. be recognized by the patient as his/her personal physician and be personally responsible for the continuity of the patient's care, at least throughout the period of hospitalization.

EXAMPLE: A supervising physician carried out all of the activities listed above for a surgical patient but (e). He/she was not present in the OR when the major surgery was performed because supervision of the 5th-year resident performing the operation was not required. A physician's charge

*The term "physician" does not include any resident or intern of the hospital regardless of any other title by which he/she is designated or his/her position on the medical staff. For example, a senior resident who is referred to as an "assistant attending surgeon" or an "associate physician" would still be considered a resident since the senior year of the residency is essential to completion of the program.

would not be recognized for the surgical procedure because criterion (e) was not met. Therefore, the physician would not be an attending physician for the period of hospital care although he might meet the criteria listed in A.2. below and be held as the attending physician for a portion of the care provided.

Even if the supervising physician chose to be present in the OR, payment could not be made to him/her for the surgical procedure since his/her presence was not medically necessary and he/she could not, therefore, function as the attending physician in connection with the surgery. However, if he/she was scrubbed and acted as an assistant, payment could be made to him/her as a surgical assistant if such an assistant was needed and another resident or physician did not fill the role (see item A.2. below).

If the supervising physician was present at surgery, and the surgery was performed by a resident acting under his/her close supervision and instruction, he/she would not be the attending surgeon unless it were customary in the community for such services to be performed in a similar fashion to private patients who pay for services rendered by a private physician.

EXAMPLE: A group of physicians share the teaching and supervision of the house staff on a rotating basis. Each physician sees patients every third day as he/she makes rounds. No physician can be held to be one of these patient's attending physician for any portion of the hospital care although consultations and other services they personally perform for the patient might be covered.

2. A teaching physician may be held to be the attending physician for a portion of a patient's hospital stay: if the portion is a distinct segment of the patient's course of treatment (e.g., the pre-operative or post-operative period) and of sufficient duration to impose on the physician a substantial responsibility for the continuity of the patient's care; if the physician, as a minimum, performs all of the activities described above with respect to that portion of the stay; and if the physician is recognized as the patient's physician fully responsible for that part of the stay. If a teaching physician is not found to be the attending physician with respect to a portion of a patient's stay, he/she may not be reimbursed for any service provided to the patient for that portion of the stay unless it is an identifiable service that he/she personally rendered to the patient.

EXAMPLE: A physician carried out all of the activities listed above for a surgical patient until midway in the post-operative period, when the physician's teaching tour of duty ended. Since he was not responsible for the continuing care of the patient throughout the post-operative period, he cannot be reimbursed as the attending physician for that period.

3. Performance of the activities referred to above must be demonstrated, in part, by notes and orders in the patient's records that are either written by or countersigned by the supervising physician.
4. The services of a teaching physician while visiting patients during grand rounds is basically teaching and does not contribute to an "attending" relationship with any of the patients visited.
5. An emergency room supervising physician may not customarily be considered to be the attending physician of patients cared for by the house staff. It is only through his/her direct personal involvement with a patient that a charge may be recognized under Part B. Such an involvement would necessarily include personal examination of the patient as well as direction of and responsibility for the treatment provided.

B. Determining the Amount Payable Under Part B

1. The amount paid for direct medical services rendered by the teaching physician should be related to only that discrete portion of the patient's care for which the physician exercised the pertinent responsibilities of an attending physician outlined in A.1. For example, if the patient's personal physician furnishes services before the hospital admission and after the discharge and the teaching physician becomes the attending physician only with respect to the inpatient care, the lesser extent of the teaching physician's service should be taken into account in recognizing a charge; otherwise, the out-of-hospital service would be billed for and paid twice. Similarly, if surgery was performed and the teaching physician rendered identifiable personal service to the patient in the operating room, it is necessary to determine whether that physician performed services more nearly analogous to a consultant, an assistant at surgery (see first "Example" in Part A), or as the "attending" surgeon in order to identify the appropriate reasonable charge. If the physician acted as the attending surgeon but did not render the pre- or post-surgical services generally performed by a private surgeon to a private patient, the difference in service should be reflected in the amount of reimbursement.
2. The following conditions should be taken into account in determining the "customary" charges of teaching physicians for services which they provide as attending physicians to Medicare beneficiaries.
 - a. If the teaching physician has a substantial practice outside the teaching setting (i.e., more than half of the time spent in the practice of medicine is spent caring for people who were his patients before they were hospitalized or who were referred to him/her by physicians responsible for their care outside the hospital setting), his/her "customary" charges for services in

the teaching setting will be related to the amounts he/she charges for similar services in his/her outside practice. Where the services performed in the teaching setting differ from those in the outside practice, reductions should be made for the lesser scope of services provided, time spent, visits or responsibility as an attending physician (not counting supervisory acts as time or visits).

- b. If the teaching physician does not have a substantial practice outside the teaching setting and the provider has established one or more schedules of charges which are collected for medical and surgical services furnished to a majority of non-Medicare teaching patients, his/her charges should be related to the provider's schedule of charges which are most frequently collected.

EXAMPLE: A hospital with an approved teaching program receives payment for physicians' services rendered to 80 percent of its non-Medicare patients. Fifty percent are paid for by public assistance under a relatively low payment schedule; 20 percent are covered under a Blue Shield Plan with a somewhat higher fee schedule and the balances are covered under commercial plans. Since collections are made for a majority of patients and the most frequently used schedule of payment is the welfare schedule, the welfare schedule of charges should serve as the basis for determining the teaching physicians' customary charges for Medicare.

- c. Where neither the physician nor the provider has established charges for the physician's services which are in effect for non-Medicare patients, the carrier and intermediary must make the necessary charge and cost determination based on that portion of the physician's compensation which is for services to patients, determined pursuant to the regulations governing reimbursement for the services of provider-based physicians.
- 3. Where teaching physicians of a hospital, billing through a hospital or other organization, adopt a uniform schedule of charges for the purpose of billing under Part B for the services they provide as attending physicians in the teaching setting, carrier acceptance of the schedule for reimbursement purposes should be based on a finding that the schedule does not exceed the average of reasonable charges which would be determined if each physician were individually reimbursed his/her reasonable charge for the services involved.
 - 4. In determining the number of visits which may be considered reasonable, e.g., in a course of treatment for which a global fee is not ordinarily charged, the total number of visits which would have been made to the patient in a nonteaching setting should be used as a guide; visits in excess of this number are presumed to be primarily for teaching purposes. Similarly, total reasonable charges for a

course of treatment in the teaching setting should be compared with and should not exceed the charges that would be expected in non-teaching settings for similar services. Also, the charges billed for an hour of a teaching physician's services should not exceed the amount of fees the physician generally receives for an hour's work in caring for nonteaching patients.

5. Where payment is made under part B on a reasonable charge basis, payment may not also be made on a cost basis to the hospital for the same service as a teaching service. Part A payments to the hospital should, therefore, not be based on the total compensation of the physician if that compensation is in part for patient care. The total compensation should be reduced by the portion paid for patient care in accordance with the applicable provisions of the principles of reimbursement for services of hospital-based physicians to arrive at the hospital cost portion. Allocation of compensation received between both parts of the program should be in accordance with how the physician's time is actually spent. If a physician's only compensation for services in a teaching setting are paid by the hospital and the agreement states that only the supervisory, and not patient care, services are compensated, it is necessary to look behind the words of the agreement by reviewing the physician's actual obligations and activities and determining whether the compensation level is reasonable for the supervisory and teaching services alone and insufficient to cover patient care services as well. The carrier and intermediary should make this finding jointly.

EXAMPLE: An employment agreement between a physician and the hospital states that he will be paid \$50,000 a year for administration, supervision and teaching. However, he spends one-half of his time in providing patient care. The carrier and intermediary determined that if his compensation were allocated solely to the time the physician spent in the performance of his hospital duties, it would yield an hourly rate of compensation about double the rate paid for similar work elsewhere in the area. Therefore, the carrier and intermediary concluded that only a portion of the compensation was for hospital activities and reimbursable under Part A. Since charges were not customarily billed for the medical services the physician provided, the remainder would serve as a basis for computing the physician's reasonable charges for patient care in accordance with B.2.b. above.

C. Carrier Responsibilities for Claims Review and Verification

1. The carrier is responsible for assuring that the bills being submitted were prepared with an understanding of the conditions governing payment for physicians' services in the teaching setting.

To help carry out this responsibility, carriers will not pay bills (SSA-1490 or SSA-1554) for services rendered in the teaching setting in any month after May 1969, unless:

- a. the chief of the department or service involved certifies on a form furnished by the carrier that each of the billed services for that month meets the pertinent requirements of A.1.; or
 - b. the bill has been signed by the attending physician and he/she understands that he/she is certifying that he/she met the requirements for those services for which the claim is made.
2. The provision of personal and identifiable services must be substantiated by appropriate and adequate recordings entered personally by the physician in the hospital or, in the case of outpatient services, outpatient clinic chart. The carrier is expected as part of its responsibilities to make appropriate checks of patient records, examining admission, progress, and discharge notes to verify that services for which charges are billed met the appropriate coverage criteria. If the carrier review shows that a significant portion of the services in the sample do not meet the criteria, appropriate steps should be taken to adjust the reimbursement.
 3. Bills must indicate when services are furnished in the teaching setting, the name of the provider and attending physician involved, and the extent of the services provided as an attending physician. The services must be defined and quantified to avoid errors in applying the reasonable charge limitation — e.g., to avoid applying the reasonable charge for a global service where only the surgical procedure or another component service was provided as an attending physician.
 4. The carrier will need to carry out the steps necessary to assure itself that these conditions set out in B.1. are met -- for example, to assure itself that any schedule of charges proposed for the teaching setting is actually applied and collected.

D. Who May Bill

Where the supervising physician is a member of a group which provides teaching services in a hospital, the Part B payment for services rendered as attending physicians by the group may be billed for:

1. by the physician or a corporation, partnership, or other organization of physicians (including an association of teaching physicians organized for the purpose of billing for and distributing insurance monies and other payments received for professional services to patients) on Form 1490,

2. by the hospital on Form 1554 provided that the carrier has determined that the certification described in C.l.a. had been executed and complied with, and
3. if the services are performed by a physician who is a faculty member of a medical, osteopathic, or dental school, by the school on Form 1490.

The individual physician's authorization is required to be on file in writing with the hospital or other organization to permit any of the above organizations to bill on his/her behalf. The organization must furnish to the Part B carrier the names of the physicians who have authorized the organization to bill on their behalf, and must agree to keep the carrier informed on a current basis of changes in membership in the group.

CHAPTER 25

COST TO RELATED ORGANIZATIONS

COST TO RELATED ORGANIZATIONS

An organization related to a provider through common ownership or control is dealt with as if it were part of the provider. If the related organization incurs costs for services, supplies and facilities which are furnished to the provider, these same costs may be included in the provider's allowable costs. The related organization is not permitted to add a profit or surcharge to its actual costs when it transfers the costs of the services, supplies or facilities to the provider. There is an additional restriction that such costs must not exceed the price of comparable services, supplies and facilities that could be purchased elsewhere.

The purpose of this rule is to prevent the program from paying a provider any profit as a result of dealing with itself through a related organization.

Related to the provider means that the provider to a significant extent is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies.

Common ownership exists when an individual or individuals have significant ownership or equity in the provider and the institution or organization serving the provider.

Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institute.

In determining whether a provider is related to a supplying organization, the tests of common ownership and control are to be applied separately.

A determination as to whether an individual or individuals have significant ownership or equity in the provider organization so as to consider the organizations related by common ownership is made on the basis of the facts and circumstances in each case. This rule applies whether the provider organization or the supplying organization is a sole proprietorship, partnership, corporation, trust or estate, or any other form of business organization, proprietary or nonprofit.

The following examples illustrate the general application of the common ownership rule. Note: The percentages used in the examples are not intended to be used in other cases for determining when significant ownership in an organization exists. Such a determination must be made on the basis of the facts and circumstances in each case.

Example No. 1

Mr. B owns 60 percent interest in the provider organization and a 55 percent interest in an organization supplying the provider. The provider and the supplying organization are considered related by common ownership since Mr. B possesses significant ownership in both organizations.

Example No. 2

Mrs. X owns a 70 percent interest in the provider organization and a 40 percent interest in the supplying organization. The remaining 60 percent interest in the supplying organization is owned in equal amounts by 20 individuals unrelated to Mrs. X. Unless the provider can demonstrate to the satisfaction of the intermediary that Mrs. X's ownership interest in the supplying organization is not significant, the organizations are considered related to each other by common ownership.

The term control includes any kind of control, whether or not it is legally enforceable and whether or not the control is actually exercised. It is the reality of the control which is decisive, not its form or how it is exercised. The facts and circumstances in each case must be examined to ascertain whether legal or effective control does, in fact, exist.

Examples of Control

Example No. 1

Dr. A is the medical director of a provider, but he does not have any ownership interest in the provider. Dr. A is also the president and owner of a supplier organization that furnishes various therapeutic services primarily to the provider. Under these circumstances, it will be presumed that Dr. A has the power to influence or direct both the provider and the supplying organization, hence the two organizations are related to each other by common control.

Example No. 2

Mrs. A owns a 60 percent interest in the provider organization. Mrs. A's two sons and her husband together own a 100 percent interest in the organization supplying the provider. Under the circumstances described, it will be presumed that Mrs. A has the power to influence and direct the actions of her family relating to the operation of the supplying organization, and that the organizations are related by common control.

Example No. 3

A construction company builds a facility and leases it to an operating company which becomes a provider. Mr. A owns a 100 percent interest in the construction company and a 35 percent interest in the operating company. Mrs. B, a key employee of the construction company, owns a 20 percent interest in the operating company. Under the circumstances described, it will be presumed that Mr. A, as the employer of Mrs. B in the construction company, can influence Mrs. B's decisions relative to the operation of the provider and that the construction company and the provider are related by common control.

Example No. 4

Mr. H owns a 45 percent interest in Corporation X, the provider organization. The remaining 55 percent interest is owned by Corporation Y, the supplying organization. Mr. H owns a 100 percent interest in Corporation Y. Mr. H controls 100 percent of Corporation X, through his own 45 percent direct interest in Corporation X and the indirect 55 percent interest owned by Corporation Y. Mr. H has complete control over both the provider and supplying organization, therefore, the organizations are related by control.

If a provider leases a facility from a related organization, the amount of rent paid by the provider to the related organization is not allowable as a cost. The provider may, however, include in its allowable costs the actual reasonable costs of ownership incurred by the related organization. Generally, the costs of ownership include depreciation, interest on the mortgage, real estate taxes, and similar expenses. The effect is to treat the leased facility as though it were owned by the provider.

Where a facility is purchased from an organization related to the purchaser by common ownership or control, the purchaser's basis for depreciation must not exceed the seller's basis less accumulated depreciation recognized under the program. Accumulated depreciation of the seller under the program must be considered as incurred by the purchaser for purposes of determining gain or loss on disposition of depreciable assets.

The same rules apply where a facility, through purchase, converts from a proprietary to a nonprofit status and the buyer and seller are related by common ownership.

Examples:

1. A construction company builds a facility for an operating company which becomes a provider. Mr. X owns a 100 percent interest in both organizations. The provider organization and the construction company are considered related, therefore, the construction company's costs of building the facility must be used by the provider as the historical cost of the facility.
2. The owners of a 200-bed hospital convert their facility to a nonprofit corporation. The owners sell the hospital to a nonprofit corporation which is under the direction of a board of trustees made up of former owners of the proprietary corporation. Both corporations are considered related organizations; therefore, the bases used for assets by the nonprofit corporation remain the same as contained in the proprietary corporation's records and there can be no increase in the book value of such assets.

There is an exception to the general rule applicable to related organizations. The exception applies if the provider can satisfy the intermediary:

1. That the supplying organization is a bona fide separate organization;
2. That a substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control, and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization.

3. That the services, facilities, or supplies are those which commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions; and
4. That the charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

Where all of the conditions of this exception are met, the charges by the supplier to the provider for such services, facilities, or supplies are allowable as costs.

For example, a druggist owns a drug store and also has a large interest in a skilled nursing facility. A substantial amount of the business of the drug store is done with the general public. Therefore, the exception to the related organization principle applies and the amounts charged to the skilled nursing facility by the drug store are allowable as costs, but not to exceed the amounts charged to the general public or to other institutions for similar services.

The exception to the related organization rule does not apply to rentals of hospital facilities, skilled nursing facilities or nursing homes. Rentals of such facilities do not meet the requirement that there be an open, competitive market for the facilities furnished. The exception rule contemplates that quantities of goods or services are made available to the general public, and the provider is part of the general public.

Disposal of Assets

Under the cost to related organizations principle, the cost of ownership (depreciation, interest, taxes, etc.) of an asset which is used in the program is includable in the allowable cost of a provider even though it is owned by a related party. Where such an asset is sold or otherwise disposed of by a related organization, any gain or loss realized by the related party must be included in the provider's cost. Likewise, where a provider claims accelerated depreciation on an asset owned by a related organization, and it either terminates participation in the program, or substantially reduces its HI utilization the excess depreciation claimed is subject to the recapture provisions described in the chapter on Depreciation. (See Section 136 of the Provider Reimbursement Manual.)

CHAPTER 26

CHAIN ORGANIZATIONS

Allocation of Home Office Costs

Pooled Costs in Home Office

Interperiod Allocation of Home Office Costs

CHAIN ORGANIZATIONS

A chain organization consists of a group of two or more health care facilities which are owned, leased, or controlled by one organization. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations which are engaged in other activities not directly related to health care. (See Chapter 10 in the Provider Reimbursement Manual (PRM) for definitions of common ownership and control.)

As you learned in the chapter on Related Organizations, Chapter 25, where a provider is furnished services, facilities, or supplies from an organization related to it by common ownership or control, the costs allowed are limited to the lower of:

- (1) allowable costs properly allocated to the provider, or
- (2) the price for comparable services, facilities, or supplies that could be purchased elsewhere, taking account of the benefits of effective purchasing that would accrue to each member provider because of aggregate purchasing on a chain-wide basis.

Home offices of chain organizations vary greatly in size, staff, mode of operations, and services furnished to the facilities in the chain. The home office of a chain is not a provider in itself; therefore, its costs may not be directly reimbursed by the program. The relationship of the home office to the Medicare program is that of a related organization to participating providers.

Home offices usually furnish central management and administrative services such as centralized accounting, purchasing, personnel services, management direction and control, and other services. To the extent the home office furnishes services related to patient care to a provider, the reasonable costs of such services are includable in the provider's cost report and are reimbursable as part of the provider's costs.

Where the home office of the chain provides no services related to patient care, neither the costs nor the equity capital of the home office may be recognized in determining the allowable costs of the providers in the chain.

Home office costs directly related to those services performed for individual providers which relate to patient care, plus an appropriate share of indirect costs (overhead, rent, administrative salaries, etc.) are allowable to the extent they are reasonable.

Costs that are not allowable costs when incurred directly by a provider are likewise not allowable when incurred by the home office. Such costs cannot be allocated by the home office to providers. For example, certain advertising costs, some franchise taxes and other similar taxes, costs of noncompetition agreements, certain life insurance premiums, certain membership costs or those costs related to nonmedical enterprises are not considered allowable home office costs.

Very often the home office of a chain organization charges the providers in the chain a management fee for the services the home office furnishes. Management fees charged between related organizations are not allowable costs, and such fees must be deleted from the provider's cost report.

On the other hand, where management fees or fees for other services are paid to an organization where there is no common ownership or control between the provider and the franchisor or service organization, such fees may be allowable if they are related to patient care and are reasonable in amount.

The organization costs of a home office are considered allowable costs under the Medicare program and must be amortized. However, reorganization costs and stockholder servicing costs are not allowable organization costs. Stockholder servicing costs include the costs of stockholders' annual reports, annual meetings, stock transfer agent fees, and accounting and legal fees for consolidating statements for SEC purposes.

Costs related to the acquisition of the capital stock of a provider, whether or not such facilities are participating or subsequently will participate in the Medicare program, are not allowable. Additionally, costs connected with the transfer of assets to a chain are not allowable as organization costs, but instead, must be capitalized as part of the costs of the assets.

Where the home office makes a loan to, or borrows from, one of the components of the chain, the interest paid is generally not an allowable costs and the interest income earned from such a loan is not used to reduce allowable interest expense.

Interest expense is allowable to the extent that the proceeds of the related loan, mortgage, bond issue, etc., are used either to acquire assets for use in patient care activities or to provide funds for operations related to patient care. Where proceeds of a loan, mortgage, bond issue, etc., are used to acquire stock ownership (as opposed to assets and liabilities) of additional facilities, the interest expense is not allowable.

Start-up costs of a home office are considered allowable costs under the Medicare program and must be amortized in accordance with the provisions of Sections 2132ff, PRM.

When a home office incurs planning costs to purchase or construct a new facility to expand, rebuild, or relocate a provider which is a member of a chain organization, such costs are allowable when:

1. They are reasonable and prudent;
2. They have been included in the historical cost of the completed facility;
3. the facility has been certified to participate in the Medicare program; and

4. The facility has been approved under Section 1122 of the Social Security Act, i.e., any expenditures for plant and equipment which exceeded \$100,000 or changed the bed capacity of the facility or substantially changed the services provided by the facility were approved by the State Planning Agency. (See Section 2422ff, PRM, and Chapter 6 in this manual.)

Any planning costs incurred to purchase land become part of the historical cost of the land and are not included in the historical cost of the depreciable assets of the completed facility. If a home office incurs planning costs for both land and a facility, and such costs cannot be specifically identified with either the land or facility, the planning costs must be allocated between the land and facility based on the ratio of the cost of each to the total cost.

If a home office abandons plans, the abandoned planning costs are treated as provided for in Section 2154.4 PRM. Any allowable abandonment costs must be directly allocated to the appropriate provider.

If a home office incurs planning costs to construct a new facility or to purchase an existing facility (excluding land) to expand a chain organization, such costs are recognized when the requirements enumerated in subsection 1 above are met.

If a home office abandons plans described above, the costs of the abandoned plans are considered an investment loss and are not allowable. Also, where plans involving the acquisition of land are abandoned, the costs of such plans are not allowable.

Payments by a home office of a chain for its providers, or individually by members of a chain, to an independent fiduciary for malpractice and comprehensive general liability insurance coverage as well as unemployment and workers' compensation will be recognized if made to a fund established in accordance with the requirements in Section 2162ff, PRM.

ALLOCATION OF HOME OFFICE COSTS

The home office starts with a trial balance of its total costs, including all costs paid or incurred for the chain providers as well as all costs paid or incurred for other components in the chain. The nonallowable costs are deleted and the remaining costs, which represent the total allowable costs, are allocated to all of the components, (providers and nonproviders), which received services from the home office.

Some chain organizations have components which are not participating providers, nor do they furnish health care services to the chain's provider components. In such cases, the allocable share of home office costs such as rent, administrative salaries, and other general overhead costs must be allocated to the nonparticipating components as well as to the provider components of the chain. All activities and functions in the home office must bear their allocable share of home office overhead and general administrative costs.

Costs Directly Allocable to Components

The initial step in the allocation of allowable home office costs to components in the chain is the direct allocation of certain costs. Allowable costs incurred for the benefit of, or directly attributable to, a specific provider or nonprovider activity should be allocated directly to the chain component for which they were incurred. For example, where such costs are paid by the home office, interest expense is allocated to the facility for which the loan was made; salaries are allocated to the facility to whose employees they apply; etc.

Costs of Home Office Operations

The allowable costs not directly allocable should be allocated among the providers and to nonprovider activities on a basis designed to allocate the costs equitably over the chain components or activities receiving the benefits of the costs and in a manner reasonably related to the services received by the entities in the chain.

Chain home offices may provide certain centralized services, such as central payroll or central purchasing, to the chain components. Where practical and the amounts are material, these costs should be allocated on a functional basis. For example, costs of a central payroll operation could be allocated to the chain components based on the number of checks issued; the costs of a central purchasing function could be allocated based on purchases made or requisitions handled.

Otherwise, these costs may be appropriately included in the pooled costs and allocated as described in the next section. The functions, or cost centers, used to allocate home office costs, and the unit bases used to allocate the costs, including those for the pooled costs described in the next section, must be used consistently from one accounting period to another.

Pooled Costs in Home Office

In each home office there will be a residual amount, or "pool," of costs incurred for general management or administrative services which cannot be allocated on a functional basis.

For home office accounting periods beginning before November 1, 1976, these costs may be allocated to the components in the chain on the bases of beds, bed days, or other bases, provided the bases used equitably allocate such costs. Where the home office cannot determine its costs by functions and allocate them on a functional basis, the home office must allocate its cost as one cost center of pooled costs.

For home office accounting periods beginning on or after November 1, 1976, the pooled costs of the home office must be allocated to the chain components in accordance with the following:

1. Where the chain consists solely of health care facilities, the pooled costs must be allocated to the components based on either inpatient days or total costs. If inpatient days are used, each facility would share in the pooled costs in the same proportion that

its inpatient days bear to the total inpatient days of all the facilities in the chain. If total costs are used, each facility would share in the pooled costs in the same proportion that its total costs (excluding home office costs) bear to the total costs of all other facilities in the chain. Total costs are costs before Medicare adjustments are made.

2. Where the chain consists of health care facilities and organizations carrying on other types of activities, such as pharmacies, construction companies, etc., the pooled costs must be allocated to the health care facilities and nonhealth care organizations on an appropriate basis depending upon the organization of the chain. The intermediary is responsible for reviewing and approving the basis used. After this initial allocation, the pooled costs allocated to the health care facilities must then be allocated to each separate facility as set forth in 1. above.

There may be times when the home office wishes to change its bases for allocation of costs, because it believes the change will result in more appropriate and more accurate allocations. The home office must make a written request, with its justification for approval of the change, to the intermediary responsible for auditing the home office cost no later than 120 days after the beginning of the home office accounting period to which the change is to apply.

The intermediary's approval of a home office request will be furnished to the home office in writing. Where the intermediary approves the home office request, the change must be applied to the accounting period for which the request was made, and to all subsequent home office accounting periods unless the intermediary approves a subsequent request for change by the home office. The effective date of the change will be the beginning of the accounting period for which the request was made.

Inclusion in Provider Costs

Home office costs directly allocated to the providers should be included in each appropriate account in the provider's trial balance and then allocated through the provider's cost-finding process. For example, the allocated share of the home office's allowable interest is included in the provider's adjusted trial balance with the provider's own allowable interest cost.

Home office costs which are not directly allocated to the provider but are allocated on a functional or pooled basis should be included in the provider's cost report as part of the provider's general and administrative cost. The allocated costs should be entered as one amount, designated under an appropriately descriptive heading such as "home office costs."

Although the share of the home office costs allocated to each provider may thereby become allowable costs under the program, the allowed costs of providers in a chain should not exceed the cost allowed for similar institutions not so affiliated. Thus, the costs of a chain provider (including any allowable home office costs) are not recognized or allowed to the extent they are found to be out of line with similar institutions in the same area.

Interperiod Allocation of Home Office Costs

When the home office accounting period differs from the cost reporting period of a chain provider, the allowable home office costs of the provider for the period covered by the home office cost statement should be included in the provider's cost report and then allocated through the cost-finding process.

An amount of allowable home office costs and equity capital for the provider for the portion of its reporting year not covered by the home office statement will be tentatively projected at a rate not in excess of the previous year's home office costs and equity capital.

Example:

The home office has an accounting year ending August 31, 1974. For that year, home office costs of \$120,000 were allocated to Provider A and \$84,000 to Provider B. Provider A's reporting year ends on December 31; Provider B's reporting year ends on March 31.

Of the \$120,000 costs allocated to Provider A, \$40,000 applies to its reporting year ended 12/31/73, covering the period from 9/1/73 to 12/31/73; and \$80,000 applies to its reporting year ending 12/31/74, covering the period from 1/1/74 to 8/31/74.

Therefore, in its cost report for the year ending 12/31/74, Provider A may include home office costs of \$40,000 projected for the period 9/1/74 to 12/31/74, which is not covered by the home office cost statement (\$10,000 per month x 4 months).

Provider A

Home office costs allocated	\$120,000
Rate per month $\$120,000 \div 12 =$	\$ 10,000

Fiscal year January 1, 1973 to December 31, 1973:

Period: 9/1/73 to 12/31/73 = 4 months @ \$10,000 =	\$ 40,000
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Fiscal year January 1, 1974 to December 31, 1974:

Period: 1/1/74 to 8/31/74	8 months @ \$10,000* =	\$ 80,000
Period: 9/1/74 to 12/31/74	4 months @ \$10,000 =	\$ 40,000

* Estimated. To be adjusted to actual amounts in following fiscal year of the home office.

Of the \$84,000 allocated to Provider B, \$49,000 applies to its reporting year ending 3/31/74, covering the period from 9/1/73 to 3/31/74; and \$35,000 applies to its reporting year ending 3/31/75, covering the period from 4/1/74 to 8/31/74. Therefore, in its cost report for the year ending 3/31/75, Provider B may include home office costs of \$49,000 projected for the period 9/1/74 to 3/31/75, which is not covered by the home office cost statement (\$7,000 per month x 7 months).

Provider B

Home office costs allocated	\$84,000
Rate per month $\$84,000 \div 12 =$	\$ 7,000

Fiscal year April 1, 1973 to March 31, 1974:

Period 9/1/73 to 3/31/74 7 months @ \$7,000 =	\$49,000
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Fiscal year April 1, 1974 to March 31, 1975:

Period 4/1/74 to 8/31/74 5 months @ \$7,000* =	\$35,000
Period 9/1/74 to 3/31/75 7 months @ \$7,000 =	\$49,000

When actual costs and equity capital in the home office are determined in the following fiscal year, the projected amounts for Provider A and Provider B are adjusted to agree with the actual amounts. Appropriate adjustments are made to each provider's reimbursement.

See Chapter 27 in this manual for instructions for computing home office equity capital.

* Estimated. To be adjusted to actual amounts in following fiscal year of home office.

CHAPTER 27

RETURN ON EQUITY CAPITAL OF
PROPRIETARY PROVIDERS

Computation of Average Equity Capital

Return on Equity Capital for
Providers in Chain Organizations

Allocation of Home Office Equity Capital

Interperiod Allocation of Home Office Equity Capital

RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

Proprietary providers generally do not receive contributions from the public, or Hill-Burton grants, or other governmental assistance for capital expenditures. This is why a reasonable return on equity capital is includable as an element of the reasonable cost of covered services furnished to Medicare patients.

Briefly, the amount of return on equity capital is computed as follows:

1. The equity capital in each month is determined and an average of the monthly amounts computed. This is the average equity capital in use during the period.
2. The average equity capital in use during the period is multiplied by a percentage applicable to the cost reporting period. The percentage is based on 1 1/2 times the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust. The actual percentage is computed monthly by HCFA and issued to providers through the intermediaries.

Definitions

The term proprietary providers means providers which operate with the expectation of earning profit for the owners, as distinguished from providers operating on a nonprofit basis. Proprietary providers may be sole owners, partners, or corporations.

Equity capital is the net worth (owner's equity) of the provider, adjusted for those assets and liabilities which are not related to patient care.

Equity capital includes:

1. The provider's net investment in plant, property, and equipment related to patient care (after deducting the related accumulated depreciation.)
2. Net working capital maintained for necessary and proper operation of patient care activities.

Providers that are members of a chain organization must also include in their equity capital a share of the equity capital of the home office. (See Section 2152 of the Provider Reimbursement Manual.)

Plant, property and equipment includes buildings, land, fixtures and equipment, goodwill, and other assets not part of current assets.

Working capital is the difference between current assets and current liabilities. For Medicare purposes, net working capital means working capital from which has been subtracted any amounts which are in excess of the amount needed for the necessary and proper operation of patient care activities.

Adjustments to Equity Capital

There are a number of adjustments required in order to arrive at an equity capital amount which represents the assets and liabilities related to patient care.

Debts representing loans from partners, stockholders, or related organizations on which interest payments are not allowable as costs are not subtracted from assets in computing the owners' equity capital. Funds obtained through such loans are considered as invested capital of the provider. By not subtracting them from assets, the equity capital of the owners is increased.

Receivables created by loans or other transfers of assets between related organizations are subtracted from assets in computing the owners' equity capital. Because the loans or transfer of assets are the same as new or additional capital investments in the receiving organization, the removal of such receivables results in the transfer of equity capital from the lender to the borrower.

Generally, reimbursement to any provider leasing facilities or equipment from a related organization is limited to the costs of ownership of the leased facilities (depreciation, taxes, interest expenses, etc.) as if the provider owned the facilities. Therefore, the owners' equity in the leased assets is includable in the equity capital of a proprietary provider.

Goodwill purchased in an acquisition of an existing organization prior to August 1970 is includable in the provider's equity capital. The amount of goodwill is determined in accordance with generally accepted accounting principles. Goodwill purchased after July 31, 1970 is not includable in the provider's equity capital.

Goodwill which has not been purchased but has been internally generated as, for example, from a reorganization of the provider, is not includable in the provider's equity capital at any time.

Gifts and grants which are unrestricted as to use are includable in the provider's equity capital. Restricted gifts and grants are not includable in the provider's equity capital.

As you learned earlier, income taxes are not allowable as costs because the tax is a tax on profit, which means it is not a cost of doing business. For purposes of determining equity capital, however, the provider's liability to pay Federal, State or local income and excess profits taxes is included in the computation of equity capital. The reason for including the provider's income tax liability is that it is an obligation to a governmental agency which reduces the equity capital.

Assets and liabilities not related to providing patient care are not includable in the provider's equity capital. Excludable assets and liabilities not specifically treated elsewhere in this chapter are discussed in the following sections.

Invested funds are funds placed in income producing activities which are not related to patient care. Any portion of the provider's general funds or operating funds invested in such activities for more than six consecutive

months not includable in the provider's equity capital. For example, funds deposited in a savings account or invested in securities or loans are considered "invested funds."

Amounts deposited in a funded depreciation account and the earnings on the funded depreciation account are not includable in equity capital. The amounts deposited represent payments received or amounts accrued for depreciation expense.

Land, buildings, or other assets acquired in anticipation of expansion are not includable in equity capital as long as they are not being used in the operation or maintenance of patient care activities. Liabilities related to these assets are also excluded. Construction-in-process and liabilities related to such construction are not includable in equity capital.

Where a provider carries life insurance on officers and key employees, with the provider designated as the beneficiary, the cash surrender value of the policy is not included in equity capital.

Prepaid premiums on life insurance carried by a provider on officers and key employees, where the provider is designated as the beneficiary, are not included when computing equity capital.

In the sale of an ongoing facility, the purchaser might pay the seller a specific amount for an agreement not to compete, generally for a stated number of years. The costs of such agreements are not included in the provider's equity capital.

The value of an asset which is leased from a nonrelated organization and treated as a virtual purchase may not be included in determining equity capital.

Where a provider maintains a self-insurance program in lieu of purchasing conventional insurance, the funds in the self-insurance reserve fund must be set aside in a segregated account to cover possible losses and not used to provide patient care. Therefore, the amount deposited in the fund and the earnings on the self-insurance reserve remaining in the fund are not included in equity capital.

Where an asset is totally or partially destroyed by a casualty, e.g., fire, earthquake, etc., the unrecovered loss, which will be recognized as a deferred charge, is not included in equity capital.

Deficits or Accumulated Losses

As a result of losses in the operation of a facility, sometimes over a number of cost reporting periods, the investment of the owners may be decreased to an amount less than the original investment or may even be eliminated. These accumulated losses are usually shown as a deficit in the Retained Earnings account or other capital account of a corporation and, where proprietorships and partnerships are concerned, are reflected in the balances in the owners' capital accounts.

Such accumulated losses are reflected on the determination of equity capital as reductions of the owners' original investment. Since equity capital is, in

effect, the net assets of the owners used during the period to provide patient care, where net assets are reduced for whatever reason, the owners' equity is reduced. Where a negative amount is shown in the owners' equity there is, of course, no basis for allowing a return on equity capital.

Computation of Average Equity Capital

The average equity capital of the provider is determined by adding to the balance of equity capital at the beginning of the reporting period, the month-by-month net changes resulting from certain specific transactions as indicated in the following sections. All elements entering into the net difference between the equity capital at the beginning of the period and the equity capital at the end of the period are accounted for in the computation.

An average amount of the monthly balances in use during the period is then computed. (See the example at the end of this chapter)

To repeat what was stated at the beginning of this chapter, the average equity capital in use during the period is multiplied by a percentage applicable to the cost reporting period. The percentage is based on 1 1/2 times the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust. The actual percentage is computed monthly by HCFA and issued to providers through the intermediaries.

Some of the specific transactions which affect equity capital are:

1. Equity Capital at the Beginning of the Period

This amount is the owners' equity in the provider's assets and liabilities related to patient care at the beginning of the cost reporting period, based on the assets and liabilities of the provider.

2. Capital Investments During the Period

This includes additional amounts of new capital invested by the owners in the patient care activities of the provider. Capital investments are included in the computation in the month in which they are invested. Transfers of stock between owners do not affect the capital invested.

3. Gain or Loss on Sale of Assets

Gains or losses on the sale of assets related to patient care are included in the computation of average equity capital in the month in which they are realized.

Ordinarily, an asset not related to patient care is excluded from equity capital. However, if an asset not related to patient care is sold and the gross receipts from the sale are put into general operating funds, the gross receipts become part of the general operating fund and are thus included in equity capital.

4. Withdrawals by Owners

Equity capital is reduced by withdrawals of cash or other assets by owners. These withdrawals may be in the form of reductions of invested capital, dividend distributions, payments of personal expenses of owners from the operating funds or other funds related to patient care, or drawings of owner's salary or living expenses not reflected in the profit or loss account. Such withdrawals are included in the calculation in the month in which they are made.

5. Loans from Owners

Loans from owners which are considered as invested capital are included in this category. Loans made are included in the calculation in the month in which they are made and repayments of loans are included in the month in which they are repaid.

6. Profits or Losses from Operations

Equity capital increases or decreases during the reporting period when net income is earned or when net losses are incurred in operations of the provider. These net increases or decreases may result from patient care activities, including Medicare, or from activities not related to patient care which increase or decrease net patient care assets.

(An example of an increase from activities not related to patient care is when revenue from nonpatient care activities is commingled with the operating fund and used in activities related to patient care.)

7. Other Increases

Equity capital may be increased by gifts or grants which are unrestricted as to use.

8. Equity Capital at the End of the Month

Where the equity capital at the end of a month, after all increases and decreases in that month have been taken into consideration, is a negative amount, a zero is shown in column 8 in the worksheet. The purpose of this principle is to give the owners credit for all their capital invested and used in patient care. A negative amount in column 8, instead of zero, would penalize the owner for not having equity capital.

Where the provider includes a distribution of equity capital from a home office (or other related organization), two additional columns must be added, thus expanding the worksheet to ten columns. The provider equity capital to be included in column 8 will be the actual amount computed by the provider, whether positive or nega-

tive. The same will be true for the monthly amounts of equity capital allocated from the home office (or other related organization) which are to be placed in column 9.

In each month, the provider equity capital and the allocated home office equity capital will then be combined in column 10. If the combined equity capital in any month, (which consists of the actual amounts in column 8 and 9) is a negative amount, a zero should be shown for that month.

The computation of average equity capital will be made with the zero included in place of the negative amount.

Examples

Following are two examples with explanatory notes of additions and subtractions which will be considered in calculating average equity capital. Example No. 1 has a positive equity capital at the beginning of the period while example No. 2 has a negative equity capital at the beginning of the period. (These examples are taken from Section 1220.5 in the Provider Reimbursement Manual.)

Data

An examination of the provider's accounting records discloses the following

Column No. 2 -- Equity capital at the beginning of the period, based on the provider's balance sheet under Medicare regulations.

Case No. 1 -- \$10,000

Case No. 2 -- (\$10,000) (Negative Equity Capital)

All other elements are considered to be identical for both case studies

Column No. 3 -- Additional investments of \$5,000 each were made in July and October.

Column No. 4 -- A loss of \$4,000 was incurred in March as a result of the sale of an asset and a gain of \$6,000 was realized in August as the result of the sale of another asset.

Column No. 5 -- Withdrawals of \$800 per month for salaries were made by the owners. These withdrawals were recorded in the owner's drawing accounts and are not included in the profit or loss computation.

Column No. 6 -- A loan of \$5,000 was made to the provider by an owner in February 1967, and repaid in July.

Column No. 7 -- Operating profit and other changes due to operations for the period amounted to \$24,000. Amounts withdrawn by the owners as salaries are not included, but amounts representing revenues from the gift shop operated by the provider are included in the \$24,000.

(NOTE: Operating profit or loss for the reporting period is treated as if it had occurred uniformly during each month of the reporting period.)

Column No. 8 When the elements of equity capital in each month result in a negative amount, or deficit, when combined into a total figure in column 8, a zero (0) is entered in this column and used in the average computation.

Computation of the amount of return is based on an assumed rate of seven percent. This rate is used only for illustrative purposes, and is not intended to be the rate which the provider will use. The actual rate is furnished by the intermediary.

The amount of reimbursable return will be determined based on the ratio of total reimbursable costs to total allowable costs. For example, if total allowable costs are \$100,000, all allocable to Medicare patients, 100 percent of the computed return is reimbursed. If \$60,000 of the \$100,000 is allocable to the program, 60 percent of the return is reimbursed. Where the reporting period is less than a full year, a proportionate amount of the return is allowable, e.g., for a seven month period, only 7/12ths of the return on equity capital is allowable.

EXAMPLE NO. 1
COMPUTATION OF RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

Month	Equity Capital Beginning of Period	Capital Investments during Period	Gain or (loss) Sale of Assets	Withdrawals or Dividend Distribution	Other Increases or (Decreases)	Increases or Decreases Due to Operations	Equity Capital End of Month (Net total of Col. 2 thru 7)
1	2	3	4	5	6	7	8
1. January	\$10,000	\$ -0-	\$ -0-	\$ (800)	\$ -0-	\$ 2,000	\$ 11,200
2. February	10,000	-0-	-0-	(1,600)	5,000	4,000	17,100
3. March	10,000	-0-	(4,000)	(2,400)	5,000	6,000	11,600
4. April	10,000	-0-	(4,000)	(3,200)	5,000	8,000	15,800
5. May	10,000	-0-	(4,000)	(4,000)	5,000	10,000	17,000
6. June	10,000	-0-	(4,000)	(1,800)	5,000	12,000	18,200
7. July	10,000	5,000	(4,000)	(5,600)	-0-	14,000	19,400
8. August	10,000	5,000	2,000	(6,100)	-0-	16,000	26,600
9. September	10,000	5,000	2,000	(7,200)	-0-	18,000	27,800
10. October	10,000	10,000	2,000	(8,000)	-0-	20,000	31,000
11. November	10,000	10,000	2,000	(8,800)	-0-	22,000	35,200
12. December	10,000	10,000	2,000	(9,600)	-0-	21,000	36,100 (a)
13. Total							\$273,600

(a) The provider's year-end balance sheet, under medicare regulations, must reflect this amount as owner's equity.

(a) The provider's year-end balance sheet, under medicare regulations, must reflect this amount as owner's equity.		Amount of Return for Twelve Month Period	
14. Total Dollars (from Col. 8, Line 13)	15. Amount allowable for current period (1/12 of line 14 for each month in the current reporting period)	Average Equity Capital During the Period	Rate of Return
\$273,600		\$22,800	7.000%
			\$1,596

EXAMPLE NO. 2 COMPUTATION OF RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

1 Month	2 Equity Capital Beginning of Period	3 Capital Investments during Period	4 Gain or (loss) Sale of Assets	5 Withdrawals or Dividend Distribution	6 Other Increases or (Decreases)	7 Increases or (Decreases) Due to Operations	8 Equity Capital End of Month (Net total of Col. 2 thru 7)
1. January	\$ (10,000) *	\$ -0-	\$ -0-	\$ (800)	\$ -0-	\$ 2,000	\$ -0-
2. February	(10,000)	-0-	-0-	(1,600)	5,000	4,000	-0-
3. March	(10,000)	-0-	(4,000)	(2,400)	5,000	6,000	-0-
4. April	(10,000)	-0-	(4,000)	(3,200)	5,000	8,000	-0-
5. May	(10,000)	-0-	(4,000)	(4,000)	5,000	10,000	-0-
6. June	(10,000)	-0-	(4,000)	(4,000)	5,000	12,000	-0-
7. July	(10,000)	5,000	(4,000)	(5,600)	-0-	14,000	-0-
8. August	(10,000)	5,000	2,000	(6,400)	-0-	16,000	6,600
9. September	(10,000)	5,000	2,000	(7,200)	-0-	18,000	7,800
10. October	(10,000)	10,000	2,000	(8,000)	-0-	20,000	14,000
11. November	(10,000)	10,000	2,000	(8,800)	-0-	22,000	15,200
12. December	(10,000)	10,000	2,000	(9,600)	-0-	24,000	16,400 (a)
13. Total							\$60,000

*Indicates Negative Equity Capital. (a) See example No. 1, Note (a)

14. Total Dollars (From Col. 8, line 13)	Number of Months Reporting Period	Average Equity Capital During the Period	Rate of Return	Amount of Return for Twelve Month Period
\$60,000	12	\$5,000	7.000%	\$ 350.00

15. Amount allowable for current period (1/2 of line 14 for each month in the current \$ reporting period

*Do not use line 15 if reporting period is full year.

RETURN ON EQUITY CAPITAL FOR
PROVIDERS IN CHAIN ORGANIZATIONS

HOME OFFICE EQUITY CAPITAL

Computation

Where a chain provider received services from the home office and the program recognizes the costs of such services for reimbursement purposes, the provider must include in its equity capital computation its proportionate share of the equity capital of the home office which is related to patient care. In the determination of home office equity capital, assets and liabilities not related to patient care activities are excluded in the computation.

The equity capital of the home office is computed generally in the same manner as for providers. That is, a calculation is made at the end of the home office's accounting period to analyze the equity capital and changes therein during the period and to determine the amounts of home office equity capital at the end of each month in the period.

However, where a negative amount is shown in the home office equity capital balance for any month, the actual negative amount of equity capital is included for that month in the provider's cost reports to determine the provider's average equity capital.

As you may recall, if a provider has a negative equity capital balance, it is shown as zero in the provider's report. However, when the home office has a negative equity capital balance to be transferred to a provider, the actual negative amount is transferred and included in the provider's equity capital. The reason is that the home office equity capital attributable to the provider is considered to be part of the provider's equity capital and must be subtracted from the provider's other capital equity to arrive at a net amount. It is only if the provider's net amount is a negative amount that the provider may use zero in its computation of equity capital.

Exclusions

1. Loans and Other Intercompany Transfers

Loans to (or from) the home office or other components of the chain from (or to) the provider cannot be considered as assets or liabilities in computing the equity capital of the home office or of the provider where interest payments are not allowable.

In addition, amounts due to (or from) the home office or other component in the chain from (or to) the provider as a result of transfers of assets between the components of the chain, or as a result of other intercompany transactions, are not includable in computing the equity capital of the home office or of the provider.

2. Assets Leased from Home Office

Where assets are leased by the provider from the home office (or other related organization) the owner's equity in the leased assets are includable in the equity capital of the provider. Therefore, the owner's equity in the asset may not be included in the equity capital of the home office; if it were, the result would be a duplication of the owner's equity in the leased asset.

The equity in the leased assets must be computed and included in the provider's equity capital in the same manner that home office equity capital is included; that is, on a month-by-month basis with negative amounts, if any, carried over to the provider from the home office.

3. Investment in Capital Stock of Provider

The home office's investment in the capital stock of the provider or of any other component in the chain and loans made to finance the purchase of such investments are not includable in the equity capital of the home office.

Allocation of Home Office Equity Capital

After the home office equity capital is determined, the home office equity capital must be allocated to the providers and other components in the chain (including nonhealth care components) which receive services from the home office.

Any assets and liabilities on the financial records of the home office, and includable in equity capital of the home office, which are directly attributable to a particular provider or other component in the chain, must be allocated directly to the particular provider or other component in the chain and included in that component's equity capital. For example, where the home office purchases equipment and transfers it to a provider, the equity in the equipment must be directly allocated to that provider. In the same manner, if the home office borrowed funds to finance the purchase of the equipment, the liability must also be allocated directly to the provider and included in the provider's equity capital computation.

Where borrowed and internally generated funds are transmitted by the home office to the providers or other entities in the chain and the funds have become so commingled as to preclude separate identification, the liability for the borrowed funds is allocated to the providers and other entities in the chain in the proportion that the funds received by that provider or other entities bear total funds disbursed.

The equity in those assets and liabilities which are directly allocable to a particular provider must be included in the computation of the average equity capital of the provider on a monthly basis. The effect of this would be the same as if the provider itself owned the assets and owed the liabilities.

The remaining home office equity capital, or "pooled" equity capital, related to patient care must be allocated to each provider and other entity in the chain. The basis used for the allocation of pooled equity capital is the ratio that the portion of home office costs allocated to each provider or other entity bears to total home office costs.

The ratio developed for each provider in the chain for the allocation of home office equity capital must be applied to the amount of equity capital computed at the end of each month in the computation of average equity capital of the home office. In effect, the home office equity capital is considered as a group of net assets used to provide services to the providers and other components in the chain.

The costs of these services allocated to the providers are considered to be a measure of the degree to which the related equity capital is used for the benefit of the providers. Each provider must include its allocated share of the pooled equity capital of the home office at the end of each month. This is necessary in the computation of its total equity capital for each respective month to determine its combined average equity capital upon which the return on equity capital is based.

REPORTING OF HOME OFFICE COSTS AND EQUITY CAPITAL

Each intermediary servicing a provider in a chain must be furnished with a detailed home office cost statement as a basis for reimbursing the provider for home office costs and equity capital. The home office cost statement must be prepared as of the end of the home office accounting year, setting forth home office costs and equity capital for the accounting year then ended. The home office cost statement may be obtained either from the chain provider or from the chain home office.

The home office cost statement constitutes the documentary support required of the provider to be reimbursed for home office costs and equity capital in the provider's cost report. Preparation of, and furnishing, the home office cost statement is a home office responsibility. If a provider or the home office does not furnish a home office cost statement to the intermediary, the intermediary will not have adequate data to support payments for home office costs and equity capital and must exclude home office costs and equity capital allocations from provider reimbursement. Corresponding changes should be made to interim rates of reimbursement affected by the exclusion of home office costs.

The cost statement should be furnished to the intermediary within 90 days after the close of the home office accounting year.

To be acceptable, the home office cost statement must be prepared in a format which contains detailed schedules of the determination of home office costs and equity capital and their allocations.

1. Home Office Costs — The determination of allowable costs of the home office should begin with:

- (A) the total costs of the home office, by cost centers, as shown by the home office general ledger trial balance;
- (B) should show the reductions for those costs which are not allowable; and
- (C) should then show the adjusted trial balance of total allowable costs.

The reductions for unallowable costs should be identified and explained on a supporting schedule.

A schedule (or schedules) for the allocation of the allowable costs to all of the components serviced by the home office must be included showing each related component in the chain and the amount of home office costs allocated to each related component. Detailed working papers should be maintained by the home office to support the allocations of costs consolidated on the statement.

The costs allocated to each provider would then be included in the provider's cost report for reimbursement by the Medicare program.

2. Home Office Equity Capital — The determination of home office equity capital should be made on a schedule similar to Supplemental Worksheet F, Part I, Cost Report Form HCFA-2552G, Return on Equity Capital of Proprietary Providers. The equity capital is determined based on the assets, liabilities, and capital account balances as set forth in the home office's balance sheet as of the end of its accounting year.

An adjusted balance sheet for the determination of equity capital for Medicare purposes must be made for both the beginning and end of the first year in the program, and at the end of each accounting year, thereafter.

A schedule similar to Supplemental Worksheet F, Part II, Form SSA-2552G, must be prepared to calculate the monthly balance of the home office equity capital. The monthly balances of equity capital must then be allocated to the providers and other entities in the chain. A schedule should be included setting forth the month-by-month distribution of the balances of home office equity capital to the entities in the chain. The amounts of home office equity capital allocated to each provider for each month in the accounting period must be combined with the provider's own equity capital for the corresponding month in its own calculation. Where negative amounts of home office equity capital have been computed, the actual negative amounts are brought forward to the provider's cost report for inclusion in its computation.

3. Bases for Allocations -- A statement must be included explaining the various home office allowable costs. Where the home office has departmentalized its home office costs by functions, i.e., accounting, personnel, purchasing, etc., and allocates such costs on an appropriate unit basis, the home office cost statement should contain a full explanation of the unit basis used in each case.

Where specific items of home office assets and liabilities are allocated directly to a particular provider or other component the statement should contain an explanation for, and the basis of, such direct allocation. The intermediary responsible for the home office audit will determine the appropriateness of the method of allocation used, in addition to the appropriateness of the bases of allocation used.

However, where "pooled" home office costs and equity capital are concerned, the bases for allocating such amounts are limited to specific ratios (See Section 2150.3D and Section 2152.3 in the PRM).

Interperiod Allocation of Home Office Costs and Equity Capital

When the home office accounting period differs from the cost reporting period of a chain provider, the allowable home office costs of the provider for the period covered by the home office cost statement should be included in the provider's cost report as indicated above and then allocated through the cost-finding process.

An amount of allowable home office costs and equity capital for the provider for the portion of its reporting year not covered by the home office statement will be tentatively projected at a rate not in excess of the previous year's home office costs and equity capital.

Example:

The home office has an accounting year ending August 31, 1974. For that year, home office costs of \$120,000 were allocated to Provider A and \$84,000 to Provider B. Provider A's reporting year ends on December 31; Provider B's reporting year ends on March 31.

Of the \$120,000 costs allocated to Provider A, \$40,000 applies to its reporting year ended 12/31/73, covering the period from 9/1/73 to 12/31/73; and \$80,000 applies to its reporting year ending 12/31/74, covering the period from 1/1/74 to 8/31/74.

Therefore, in its cost report for the year ending 12/31/74, Provider A may include home office costs of \$40,000 projected for the period 9/1/74 to 12/31/74, which is not covered by the home office cost statement (\$10,000 per month x 4 months).

Provider A

Home office costs allocated	\$120,000
Rate per month $\$120,000 \div 12 =$	\$ 10,000

Fiscal year January 1, 1973 to
December 31, 1973:

Period: 9/1/73 to 12/31/73 = 4 months @ \$10,000 = \$ 40,000

Fiscal year January 1, 1974 to
December 31, 1974:

Period: 1/1/74 to 8/31/74 = 8 months @ \$10,000*	\$ 80,000
Period: 9/1/74 to 12/31/74 = 4 months @ \$10,000	\$ 40,000

* Estimated. To be adjusted to actual amounts in following fiscal year of the home office.

Of the \$84,000 allocated to Provider B, \$49,000 applies to its reporting year ending 3/31/74, covering the period from 9/1/73 to 3/31/74; and \$35,000 applies to its reporting year ending 3/31/75, covering the period from 4/1/74 to 8/31/74.

Therefore, in its cost report for the year ending 3/31/75, Provider B may include home office costs of \$49,000 projected for the period 9/1/74 to 3/31/75, which is not covered by the home office cost statement (\$7,000 per month x 7 months).

Provider B

Home office costs allocated	\$ 84,000
Rate per month $\$84,000 \div 12 =$	\$ 7,000

Fiscal year April 1, 1973 to
March 31, 1974:

Period: 9/1/73 to 3/31/76 = 7 months @ \$7,000 \$ 49,000

Fiscal year April 1, 1974 to
March 31, 1975:

Period: 4/1/74 to 8/31/74 = 5 months @ \$7,000*	\$ 35,000
Period: 9/1/74 to 3/31/75 = 7 months @ \$7,000	\$ 49,000

* Estimated. To be adjusted to actual amounts in following fiscal year of the home office.

When actual costs and equity capital in the home office are determined in the following fiscal year, the projected amounts for Provider A and Provider B will be adjusted to agree with the actual amounts. Appropriate adjustments are made to each provider's reimbursement.

CHAPTER 28

UTILIZATION REVIEW (UR) AND
PROFESSIONAL STANDARDS REVIEW
ORGANIZATIONS (PSROs)

Utilization Review in Hospitals

Utilization Review in Skilled Nursing Facilities

Delegated Hospital PSRO Review

Long Term Care PSRO Review

UTILIZATION REVIEW (UR)

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSROs)

Utilization Review (UR)

One of the original conditions for participation in the Medicare program was that a hospital or a skilled nursing facility (SNF) must have an established utilization review (UR) plan. The purpose of UR is to ensure that the services to Medicare inpatients and the patients' continued stays in the hospital or SNF are medically necessary. UR also reviews whether the patients could receive adequate health care services as an outpatient or in a more economical health care facility of a different type.

The law required that such a plan must provide for:

- (1) Committee review of admissions, length of stays, ancillary services furnished (including drugs) and professional services furnished. The review could be made on a sample or other basis;
- (2) Notification to the patient and his attending physician in any case in which it is determined that admission to, or further stay in the institution is not medically necessary; and
- (3) Review of each case of continuous extended stay during the patient's confinement in the hospital or skilled nursing facility.

The utilization review plan had to be one that would enable the hospital or skilled nursing facility to maintain a high quality of patient care and use the hospital or SNF more effectively and efficiently.

Utilization review is a provider function and reimbursement for utilization review can be made only to the provider as a part of the providers' reasonable cost. No payment for utilization review can be made by the program directly to physicians or to utilization review committees. Costs incurred by the provider in connection with utilization review are includable in reasonable costs as set forth in the following sections.

1. UTILIZATION REVIEW IN HOSPITALS

- A. Costs of physicians' services -- Where utilization review covers the entire patient population of a hospital, payments made to physicians by the provider for their services on utilization review committees are allowable as costs. Allowable costs are limited to payment of a reasonable compensation to the physician. Such costs are then apportioned among all of the users of the hospital as part of administrative costs.

Where utilization review covers only Medicare beneficiaries, payments made to physicians for their services on utilization review committees are not allowable as costs.

- B. Costs other than for physicians' services -- All reasonable costs of utilization review other than for physicians' services are allowable costs and are apportioned among all of the users of the facility. Included in these costs are costs related to the services of professional personnel other than physicians, report writing, etc. Utilization review costs other than for physicians' services are allowable whether or not the utilization review covers the entire patient population.

2. UTILIZATION REVIEW IN SKILLED NURSING FACILITIES (SNFs)

- A. Payments made to physicians by the provider for their services on utilization review committees are allowable as costs, whether or not the utilization review covers the entire patient population of the skilled nursing facility. Allowable costs are limited to the payment of a reasonable compensation to the physician.

Where utilization review covers only Medicare beneficiaries, compensation to physicians for their utilization review services is reimbursable 100 percent by the Medicare program.

Where the utilization review committee activities apply to more than Medicare covered services, but a valid allocation between Medicare and other programs is not supported by documentation, all utilization review costs for physicians' services should be apportioned among all users of the skilled nursing facility (SNF).

- B. Administrative costs related to utilization review and costs of professional personnel other than physicians are allowable costs and are apportioned among all of the users of the SNF, whether or not utilization review covers the entire patient population.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSROs)

The 1972 Amendments made some major changes in the utilization requirements. Under these provisions, the Secretary was required to establish independent Professional Standards Review Organizations (PSROs), consisting of substantial numbers of practicing physicians (usually 300 or more) in local areas to assume responsibility for comprehensive and ongoing review of services covered under the Medicare, Medicaid, and Maternal and Child Health programs.

The purpose of these organizations, as stated in the law, was "to promote the effective, efficient, and economical delivery of health care services of proper quality for which payment may be made..." under the Act. The PSRO was responsible for assuring that payments for health care services under these programs will be made:

- (1) only when medically necessary, as determined in the exercise of reasonable limits of professional discretion; and
- (2) in the case of inpatient services, only when and for such period as such services cannot, consistent with professionally recognized health care standards, effectively be provided on an outpatient basis or more economically in an inpatient health care facility of a different type.

Participation in a PSRO was voluntary and open to every physician in the area. Existing organizations of physicians were encouraged to take the lead in urging their members to participate. No physician was barred from participation because he or she was not a member of any organized medical group. A physician could not be required to join any such group for the privilege of becoming a member or an officer of any PSRO. There was to be no discrimination in assignments to perform PSRO duties based on membership or nonmembership in any such organized group of physicians.

The 1972 Amendments required the Secretary, following consultation with national, State and local, and public and private medical care organizations and medical societies, to tentatively designate PSRO areas throughout the country by January 1, 1974.

In smaller or more sparsely populated States, the designations are on a Statewide basis. Each area, defined in geographic or medical service area terms, generally includes a minimum of 300 practicing physicians -- in most cases substantially more than that number. Because of the minimum number of physicians required -- intended to assure broad, diverse, and objective representation -- there are many multi-county PSRO areas. The designation of areas is required to be consistent, as far as practicable, with political boundaries, local patterns of medical practice, as well as with effective coordination with Medicare and Medicaid fiscal intermediaries.

PSRO physicians engaged in the review of the medical necessity for hospital care and justification of need for continued hospital care must be active hospital staff members. The purpose of this rule is to assure that only doctors knowledgeable in the provision and practice of hospital care will review such care.

Under the amendments, a physician is not permitted to review services for which he or she is directly responsible or services in an institution in which he or she or a member of his or her family has a "significant" financial interest.

When a given PSRO is found competent to perform the required review functions, the requirement that providers establish utilization review committees no longer applies.

Christian Science sanatoria operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Mass., are exempt from compliance with PSRO requirements.

Delegated Hospital Review

The PSRO review system requires cooperation between the PSRO and the hospitals in the area.

When a PSRO finds that a hospital is capable and willing to perform admission reviews, continued stay reviews, and medical care evaluation studies of inpatient short-stay hospital care, the PSRO may delegate the responsibility to the hospital.

When such delegation occurs, the PSRO continues to be responsible for assuring that the review performed by the hospital is effective. Thus, the PSRO will monitor and periodically evaluate the hospital's performance in a manner consistent with PSRO program criteria and guidelines. If the hospital fails to perform effectively, the PSRO would withdraw the delegation and conduct review in another manner.

Where hospitals are performing delegated review, reimbursement for the direct costs of delegated review is made on the basis of a unit cost rate per admission. The unit cost rate is based on annual estimates of costs submitted by each hospital on form BQA-153, Delegated Hospital Function Cost Summary. Direct costs are those for physicians, physician-advisors, other health care professionals, and technical/support personnel, applicable fringe benefits and training and travel directly associated with PSRO-delegated hospital review function.

Indirect costs incurred by the hospital in connection with delegated review are accounted for under the appropriate general services cost center for Medicare reporting purposes. Included in indirect costs are administrative costs, utilities, maintenance, space, depreciation, office supplies, etc.

Long Term Care Review

In addition to reviewing care delivered in short-stay hospitals, PSROs are authorized to assume responsibility in long term care delivered to Medicare, Medicaid, and Maternal and Child Health patients in skilled nursing facilities.

The PSRO review of long term care combines the admission review with the continued stay review. In other words, the PSRO certifies that the admission is medically necessary for long term care.

Adjustments of the Trust Funds

The 1975 Amendments to the Social Security Act (PL 94-182) permitted the full cost of performing PSRO review on Medicare patients, Medicaid patients, and Maternal and Child Health patients in hospitals to be paid through the Medicare Trust Funds. Appropriate adjustments are made to the trust funds subsequently from Medicaid and Maternal and Child Health benefit payment funds for the cost of reviewing Medicaid and Maternal and Child Health hospital admissions.

(See chapter 21 in the Provider Reimbursement Manual for more specific details about reimbursement for Utilization Review. Likewise, see 1975 Amendments, Supplement I in the Provider Reimbursement Manual for more specific details about reimbursement for PSROs and delegated hospital reviews.)

CHAPTER 29

HEALTH MAINTENANCE ORGANIZATIONS (HMOs) AND GROUP PRACTICE PREPAYMENT PLANS (GPPPs)

Introduction

Reimbursement of GPPPs

Reimbursement of HMOs

Mature and Developing HMOs

HEALTH MAINTENANCE ORGANIZATIONS AND GROUP PRACTICE PREPAYMENT PLANS

INTRODUCTION

Although Health Maintenance Organizations and Group Practice Prepayment Plans are not "providers" under Medicare rules, they are an important and growing segment of the health care industry. This chapter will describe in general terms what they are, how they work and how they are reimbursed by the Medicare and Medicaid programs.

The prevalent and traditional form of medical practice in the United States is fee-for-service. A patient pays the physician for services, usually after the patient has been treated for an illness. However, there is a comparatively small group of Health Maintenance Organizations (HMOs) and Group Practice Prepayment Plans (GPPPs) which provide health care to enrolled members on a prepaid basis.

In general, the major difference between a GPPP and an HMO, under Medicare rules, is that a GPPP is required to furnish only Part B Medical services to its members but an HMO is required to furnish both Part A provider services and Part B medical services to its members.

Usually, the HMO or GPPP enrolls members in a health plan in which the HMO or GPPP assumes the responsibility to provide comprehensive health maintenance and treatment services. The enrolled members pay a predetermined, fixed fee periodically (usually monthly) whether or not they require or use any medical services. On the other hand, the fixed fee is paid periodically during the year regardless of the number or intensity of health services required or used by the enrolled member.

To supply the comprehensive health maintenance and treatment services, the HMO or GPPP makes formal arrangements with a number of physicians to provide certain services on a full-time basis to the plan's members. The arrangements with the physicians are usually on a non-fee-for-service basis. The fact that the contractual arrangements with the physicians are on a non-fee-for-service basis is an incentive to the HMO or GPPP and to its physicians to operate as efficiently as possible and to keep the enrolled members as healthy as possible. It is obvious that there will be more profit for the HMO or GPPP and its physicians if the health plan members need or use fewer major medical services.

In addition to arrangements with full-time physicians, many HMOs and GPPPs make arrangements with other physicians on a part-time basis or on a fee-for-service basis, depending on circumstances and needs.

A substantial part of the enrollment in HMOs or GPPPs is employment-based, i.e., through arrangements with employer-labor health plans, or from public programs such as Medicaid. Enrollees in HMOs or GPPPs have an option, usually once a year, to change from the HMO or GPPP to other kinds of coverage, e.g., Blue Cross/Blue Shield or insurance company indemnity plans.

Examples of some nationally known HMOs and GPPPs include the Kaiser Foundation Health Plan in Oakland, California; the Group Health Cooperative of Puget Sound in Seattle, Washington; and the Health Insurance Plan of Greater New York in New York City.

Reimbursement of GPPPs

A Group Practice Prepayment Plan (GPPP) may elect to be reimbursed on a reasonable cost basis for Part B medical and other health services furnished to its members. GPPPs which elect the reasonable cost basis of reimbursement deal directly with the Health Care Financing Administration (HCFA), through the Office for Direct Reimbursement.

GPPPs also have an option to elect to be reimbursed on a reasonable charge basis. Such GPPPs are assigned to an area carrier and submit bills to that carrier. The billing is on Form HCFA-1556 which contains an assignment at the bottom of the form to advise the carrier that the GPPP has an assignment on file from the beneficiary for whom payment is being requested. In addition, the GPPP agrees that under the terms of the assignment, the reasonable charge for any service as determined by the carrier shall be the full charge for the service.

(See Group Practice Prepayment Manual, HIM-8, for details).

Medicare makes interim payments to HMOs and GPPPs through "capitation payments." The basis for the interim payment is the estimated cost per capita of providing covered services to Medicare beneficiaries enrolled in the HMO or GPPP. Final reimbursement is based on the reasonable cost of providing covered services, just as it is for providers under the Medicare program.

As mentioned previously, GPPPs are required by Medicare to furnish only Part B medical services to their enrollees. Although the GPPPs may furnish both Part A and Part B services if they wish, the original Medicare law permitted interim capitation payments only for the Part B services. If the GPPP also furnished Part A services to its Medicare enrollees, Medicare reimbursed the GPPP for the Part A services in the same manner that Medicare reimbursed other providers of Part A services.

This restriction created a hardship in reimbursement to the GPPPs which furnished both Part A and Part B services to their members. GPPPs, traditionally, have charged their members a single capitation fee for all services. Medicare reimbursed the GPPPs on a capitation rate for Part B services but reimbursement for GPPP Part A services required the GPPP to prepare the usual Part A cost reports required of all providers. Of course, final reimbursement to the GPPP was based on the actual reasonable costs of providing covered services.

Reimbursement of HMOs

The 1972 Amendments to the Social Security Act changed this restriction. The 1972 Amendments set up a category called Health Maintenance Organizations (HMOs) which are similar to Group Practice Prepayment Plans (GPPPs) except that HMOs are required to furnish both Part A and Part B services to their members. The Amendments permitted prospective Medicare payments to be made to HMOs:

- (1) on an incentive capitation basis in the case of certain "mature" HMOs, or

- (2) a costs only per capita rate system in the case of "developing" HMOs or mature HMOs which have insufficient operating experience or have elected the costs only reimbursement.

The provision is designed to relate Medicare to HMOs in a way that conforms more nearly to their usual way of doing business. The objective is to provide, in the case of Medicare beneficiaries, the same kind of financial incentives that HMOs have with respect to their other enrollees. Because a health maintenance organization receives a fixed annual payment from enrollees regardless of the volume of services rendered, there is a financial incentive to control costs and to provide only the least expensive service that is appropriate and adequate for the enrollee's needs. Moreover, such organizations take responsibility for deciding what services the patient should receive and then seeing that those are the services he gets.

Mature and Developing HMOs

A mature HMO is defined as an organization which is in full compliance with the conditions and applicable standards in the regulations. Where a mature HMO additionally meets operating experience requirements necessary to be eligible for risk-basis payments under Medicare, it may elect to be reimbursed on a risk basis or to be reimbursed on a reasonable-cost basis. Mature HMOs which do not meet the added requirement necessary to qualify for risk-basis payments are eligible to be paid on a reasonable-cost basis only.

A developing HMO is subject to less demanding requirements initially, but must have a reasonable prospect of meeting the qualifications for "mature" status within three years of its initial contract. In general, HMOs with less than two years' operating experience are not apt to have a Medicare population large enough to provide a satisfactory basis for the determination of actuarially sound rates. Reimbursement to developing HMOs may, therefore, only be made on a reasonable-cost basis.

Cost-basis and risk-basis HMOs

For reimbursement purposes, a distinction is made between HMOs which contract with the Medicare program on an incentive (or risk) basis and those which contract on a cost basis.

A cost-basis HMO is either a mature or developing HMO which enters into a cost reimbursement contract with the Secretary under Section 1976 of the Act. Such HMOs are reimbursed by the Medicare program for the reasonable cost of providing covered items or services to Medicare enrollees.

On the other hand, a risk-basis HMO is a mature HMO which meets additional size and experience requirements (e.g., where the HMO serves an urban geographic area it must have a current enrollment of at least 25,000 prepaid members) and elects to enter into an incentive reimbursement contract with the Secretary.

A risk-basis HMO must provide the same range of covered Medicare services required of cost-basis, mature HMOs, and must also assume financial responsibility for covered items and services furnished to its Medicare enrollees by a physician, supplier or provider of services outside the HMO, where such services are:

- (1) emergency services; or
- (2) urgently needed services; or
- (3) other covered Medicare items or services which are determined by the Secretary not to have been made reasonably available by the HMO to its Medicare enrollees.

Medicare enrollees in a risk-basis HMO are "locked in" to receive services only from the HMO. No payments may be made to the beneficiary or on his or her behalf by the Medicare program for any services he or she receives which are not provided directly or through arrangements by the risk-basis HMO.

A risk-basis HMO is also reimbursed by the Medicare program based on the reasonable cost of providing covered services to Medicare enrollees. However, the total reasonable cost of providing covered services to enrolled Medicare beneficiaries is divided by the total number of Medicare enrollee months to determine the HMO's adjusted incurred cost on a monthly per capita basis. This amount is then compared to the adjusted average per capita cost (AAPCC) to determine if the HMO has a "savings" (profit) or a loss.

The AAPCC is the average cost of providing covered items or services in the HMO's enrollment area to Medicare beneficiaries not enrolled in the HMO. the AAPCC is determined by actual experience and includes adjustments to assure actuarial equivalence such as age, sex, race, disability status, and other relevant factors.

If the HMO's adjusted incurred cost is less than the AAPCC, the HMO and the Medicare program share equally in the savings up to 20% of the AAPCC. Savings in excess of 20% of the AAPCC accrue to the Medicare Program. The effect is to limit an HMO's profit to ten percent of the AAPCC.

If the HMO's adjusted incurred cost is less than the AAPCC, the HMO is reimbursed only the amount of the AAPCC and absorbs the excess as its loss. These losses may be carried forward and offset against future savings.

An HMO that enters into a risk-sharing contract and has voluntarily terminated it, may not enter into such a contract again.

HMO Reimbursement

Except for the computation of profit or loss for Risk HMOs discussed above, reimbursement requirements and techniques for cost and risk HMOs are essentially the same.

An interim monthly per capita reimbursement rate is established for each HMO based on the HMO's budget and enrollment forecast, which must be submitted at least 90 days prior to the beginning of their Medicare contract period. This interim rate (which for a risk HMO cannot exceed the estimated AAPCC) is paid each month, in advance, for each Medicare beneficiary enrolled in the plan.

Within 60 days after the end of each quarter, the HMO must submit a quarterly report which reflects the actual costs and enrollment for the period. This quarterly report is the basis for making any necessary adjustments in the interim rate.

A final certified cost report must be submitted within 180 days after the end of the Medicare contract period. An independent accountant must certify that the report contains the costs incurred for furnishing covered services to Medicare enrollees as determined under the Medicare reimbursement principles.

The cost finding and apportionment procedures for HMOs are very similar to those used for providers. A return on equity capital is permitted for proprietary hospitals and skilled nursing facilities owned by an HMO under the same regulations applicable to provider reimbursement. The related organization principle applied to providers is also applied to HMOs. Reimbursement to HMOs, like provider reimbursement, is based on reasonable cost. The Secretary is expected to assure, through audit or other appropriate procedures, that the costs reimbursed to HMOs by the Medicare program are not excessive.

An HMO can elect to have its Part A providers reimbursed through the normal intermediary payment process. In such instances, the HMO's interim rate does not include the Medicare program's costs for Part A services, since these costs are being paid by the intermediaries, rather than by the HMO. This option permits the providers to use the same statistical and billing procedures for all Medicare patients and not have to keep separate statistics for the HMO's Medicare enrollees.

The HMO can also elect to pay Part A providers directly. Those providers with whom the HMO has arrangements must agree to keep separate statistics for the HMO's Medicare enrollees to enable the provider to apportion costs to these enrollees on their Medicare cost report. Regardless of the amount paid by the HMO to the providers (charges, fixed per diem rate, etc.) the Medicare program will reimburse the HMO no more than the reasonable cost of the covered services furnished as determined under the Medicare reimbursement principles. Because of this provision, most HMOs who do not own or control their providers elect to have providers reimbursed through the intermediaries.

CHAPTER 30

GLOSSARY

GLOSSARY

A

AAPCC - See Adjusted Average Per Capita Cost.

ACCELERATED DEPRECIATION - Any method of calculating depreciation charges where the charges get progressively smaller; consequently the greater part of depreciation is taken during the early years of the life of the asset.

Examples are double-declining-balance and sum-of-the-years'-digits methods.

ACCOUNTING - An information system conveying information about a specific entity. The information is in financial terms and is restricted to information that can be made reasonably precise. The American Institute of CPAs, (AICPA) defines accounting as a service activity whose "function is to provide quantitative information, primarily financial in nature, about economic entities that is intended to be useful in making economic decisions."

ACCOUNTING PERIODS - The time period for which operating statements, such as the income statement and the cost reports, are prepared.

ACCOUNTING PRINCIPLES - The principles that explain current accounting concepts and practices and guide in the selection among alternative treatments for reporting transactions.

ACCOUNT PAYABLE - A liability representing an amount owed to a creditor, usually arising from purchase of merchandise or materials and supplies; not necessarily due or past due.

ACCOUNT RECEIVABLE - A claim against a debtor usually arising from sales or services rendered; not necessarily due or past due.

ACCRUAL - Recognition of an expense (or revenue) and the related liability (or asset) in the period in which it occurs regardless of when it is actually paid or received. For example, recognition of interest expense owed at the end of a period even though the interest will not be paid until the next period.

ACCRUAL BASIS OF ACCOUNTING - The method of recognizing revenues as services are rendered and expenses as they are incurred independent of the time when funds are received or expenditures are made.

ACCUMULATED DEPRECIATION refers to the total accumulated depreciation charges on an asset since it was acquired. The account used may be titled "Allowance for Depreciation" or "Reserve for Depreciation" or some similar term.

ACQUISITION COST of an asset includes the net invoice price plus all expenditures to put the asset in place for its eventual use. The other expenditures include such things as legal fees, transportation charges, and installation costs.

ACTUAL COST (BASIS) - Acquisition or historical cost.

ACTUARIAL refers to statistical computations or analyses that involve both compound interest and probabilities, often in connection with life expectancy.

ADJUSTED AVERAGE PER CAPITA COST (AAPCC) is the average cost of providing covered services in a Health Maintenance Organization's (HMO) area to Medicare beneficiaries not enrolled in the HMO. The AAPCC is determined by actual experience and includes actuarial adjustments for age, sex, race, and disability status, and other relevant factors.

ADJUSTED BASIS - The basis used to compute gain or loss on disposition of an asset for tax purposes or for Medicare reimbursement.

ADJUSTED TRIAL BALANCE - Trial balance taken after adjusting entries but before closing entries.

ADJUSTING ENTRY - An entry made at the end of an accounting period to record a transaction or other accounting event, which for some reason has not been properly recorded during the accounting period.

ADJUSTMENT - A change in an account produced by an adjusting entry.

ADMINISTRATIVE EXPENSE - An expense incurred for the enterprise as a whole, contrasted to expenses incurred for more specific functions such as manufacturing or selling.

AFFILIATED COMPANY - A company controlling or controlled by another company.

AGED DAY means a day of care rendered to an inpatient 65 years of age or older.

AGING ACCOUNTS RECEIVABLE - The process of classifying accounts receivable by the time elapsed since the debt came into existence for the purpose of estimating the amount of uncollectible accounts receivable as of a given date.

AICPA - See American Institute of Certified Public Accountants.

ALLOCATE - To spread a cost from one account to several accounts, to several products, or to several periods.

ALLOWANCE IN LIEU OF SPECIFIC RECOGNITION OF OTHER COSTS - The allowance in lieu of specific recognition of other costs was eliminated for cost-reporting periods ended after June 30, 1969. This allowance was partly in lieu of direct interest return on the equity capital of providers and partly recognition of the lack of precision in cost finding in the early stages of the Medicare program, as well as in lieu of other elements of cost not specifically recognized.

For nonprofit providers, the allowance was two percent of the total cost, exclusive of interest expense and the return allowed on equity capital. The allowance for proprietary providers was one and one-half percent.

ALLOWANCES are deductions granted or accepted by the creditor for damage, delay, shortage, imperfection or other cause, excluding discounts and refunds.

AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS (AICPA) is the organization that represents practicing CPAs.

AMORTIZATION is the general process of allocating acquisition cost of assets to the periods of benefit. It is called depreciation for plant assets; depletion for wasting assets (natural resources); and amortization for intangibles.

ANCILLARY SERVICES includes special items and services for which charges are customarily made in addition to a routine service charge. Examples are laboratory, radiology, drugs, delivery room, operating room, recovery room, and therapy services.

ANNUAL REPORT - A report for stockholders and other interested parties usually prepared once a year; includes a balance sheet, and income statement, a statement of changes in financial position, the auditor's report, and, perhaps, comments from management about the year's events.

ANNUITANT - One who receives an annuity.

ANNUITY - A series of payments, usually at equally spaced time intervals.

APPRAISAL is the process of determining an amount for an asset or liability that involves expert opinion rather than explicit market transactions.

APPRECIATION refers to an increase in economic worth caused by rising market prices.

APPROVED EDUCATIONAL ACTIVITIES means formally organized or planned programs of study engaged in by staff members of a provider, as distinguished from "on-the-job," "inservice," or similar work-learning programs.

ARM'S LENGTH refers to a transaction negotiated by unrelated parties, each acting in his or her own self interest.

ASSET refers to the book value of the property owned. In technical accounting terms, an asset means a future benefit or service potential recognized only when a transaction has occurred. Assets may be tangible or intangible, short term or long term.

AUDIT means a systematic inspection of accounting records to determine the accuracy and acceptability of the accounting records. The inspection includes analyses, tests, and confirmations.

AUDIT PROGRAM - The procedures followed by the auditor in carrying out the audit.

AUDIT TRAIL - A reference to an underlying source record or document which enables an auditor to check the accuracy of accounting records.

AUDITOR - One who checks the accuracy and general acceptability of accounting records and statements.

AUDITOR'S OPINION - Auditor's report.

AUDITOR'S REPORT - The auditor's statement of the work he had done and his opinion of the financial statements. Opinions are usually unqualified ("clean"), but may be qualified, or the auditor may disclaim an opinion in his report.

AVERAGE - The arithmetic means of a set of numbers; obtained by adding the number of items and dividing the total by the number of items.

AVERAGE COST PER DAY - Is computed by dividing the total allowable cost by the total inpatient days.

BAD DEBTS are amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services.

BAD DEBT RECOVERY - Collection, perhaps partial, of a specific account receivable previously written off as uncollectible.

BALANCE - The difference between the sum of debit entries minus the sum of credit entries in an account. If positive, the difference is called a debit balance; if negative, a credit balance.

BALANCE SHEET - A statement of financial position which shows total assets = total liabilities + proprietorship.

BASIS - Acquisition cost, or some substitute therefore, of an asset, used in computing gain or loss on disposition or retirement.

BETTERMENT - An improvement.

BIG EIGHT - The eight largest public accounting (CPA) partnerships. In alphabetical order, they are Arthur Andersen and Co.; Coopers and Lybrand; Deloitte, Haskins and Sells; Ernst and Whinney; Peat, Marwick and Mitchell; Price Waterhouse and Co.; Touche Ross and Co.; and Arthur Young and Co.

BENEFIT PERIOD begins on the first day a Medicare beneficiary enters a qualified hospital or skilled nursing facility. The benefit period ends as soon as the beneficiary has not been an inpatient of any hospital or other facility primarily providing skilled nursing services or rehabilitative services for 60 successive days.

BILLING COSTS - Generally include all costs related to charging patients for the services they received. These costs include preparing bills, keeping records of accounts receivable and collections, follow-ups on delinquent accounts, costs of collection agencies, etc.

BOND - A certificate to show evidence of debt. The par value is the principal or face amount of the bond payable at maturity. The coupon rate is the amount of interest payable in one year divided by the principal amount. Coupon bonds have attached to them coupons which can be redeemed at stated dates for interest payments. Normally, bonds are issued in \$1,000 units and carry semiannual coupons.

BOND DISCOUNT - From the standpoint of the issuer of a bond at the issue date, the excess of the par value of a bond over its initial sales price. From the standpoint of a bondholder, the difference between face amount and selling price when the bond sells below par.

BOND INDENTURE - The contract between an issuer of bonds and the bondholders.

BOND PREMIUM - Exactly the same as bond discount except that the issue price (or current selling price) is higher than par value.

BOND REDEMPTION - Retirement of bonds.

BOND REFUNDING - To incur debt, usually through the issue of new bonds, intending to use the proceeds to retire an outstanding bond issue.

BONUS - Premium over normal wage or salary paid to employees, usually for meritorious performance.

BOOKKEEPING - The process of analyzing and recording transactions in the accounting records.

BOOK OF ORIGINAL ENTRY - A journal such as the Cash Receipts Journal or the Cash Disbursement Journal.

BOOK VALUE - The net amount of an asset or a group of assets, e.g., original cost reduced by amortization or depreciation. The book value of a firm is the excess of total assets over total liabilities.

BOOT - The additional money paid or received along with used item in a trade-in or exchange transaction for a new item.

BUDGET - A financial plan that is used to estimate the results of future operations. Frequently used to help control future operations.

BUY-IN AGREEMENTS - Many States pay the monthly premiums for Medicaid patients who are eligible for Part B of Medicare. These buy-in agreements allow Medicare coverage for Medicaid/Medicare patients who cannot afford to pay the Part B premium on their own.

CALLABLE BOND - A bond for which the issuer reserves the right to pay a specific amount, the call price, to retire the obligation before maturity date. If the issuer agrees to pay more than the face amount of the bond when called, the excess of the payment over the face amount is the call premium.

CAPITAL usually means the owner's equity in a business. It is sometimes used to mean the total assets of a business or to mean capital assets.

CAPITAL ASSET - An asset whose benefit is to be used over a long period of time rather than in the period of acquisition.

CAPITAL BUDGET - Plan of proposed outlays for acquiring long term assets and the means for financing the acquisitions.

CAPITAL EXPENDITURE (outlay) - An expenditure for capital assets.

CAPITAL GAIN - The excess of proceeds over cost, or other basis, from the sale of a capital asset as defined by the Internal Revenue Service. If the capital asset is held more than one year before sale, then the tax on the gain is computed at a rate lower than is used for other gains and ordinary income.

CAPITAL RELATED COSTS include depreciation, rent, insurance and interest.

CAPITALIZATION OF A CORPORATION - A term used by investment analysts to indicate stockholders' equity plus the par value (sometimes book value) of bonds outstanding.

CAPITALIZE - To record an expenditure that may benefit a future period as an asset rather than to treat the expenditure as an expense of the period of its occurrence.

CAPITAL LOSS - A negative capital gain; the excess of cost over proceeds.

CAPITAL STOCK - The ownership shares of a corporation. Consists of all classes of common and preferred stock.

CAPITATION PAYMENTS are Medicare interim payments to Health Maintenance Organizations (HMOs) or to Group Practice Prepayment Plans (GPPPs). The basis for the payment is the estimated per capita cost of providing covered services to Medicare patients enrolled in the HMO or GPPP.

CAPTIVE INSURANCE COMPANIES - See limited insurance companies.

CARRYBACK, CARRYFORWARD, CARRYOVER - The use of losses in one period to reduce income taxes payable or gains in other periods.

CASH - Money, negotiable checks, and balances in bank demand deposits.

CASH BASIS - In contrast to the accrual basis, a system of accounting in which transactions are recorded if and only if cash is paid or received. No attempt is made to match revenues and expenses in determining income.

CASH CYCLE - The period of time that elapses during which cash is converted into inventories, inventories are converted into accounts receivable, and receivables are converted back into cash.

CASH DISCOUNTS are reductions granted for the settlement of debts within a stipulated period before they become due. Thus, the terms "2/10, net 30" on a vendor invoice mean that a two percent discount from the purchase price will be allowed if payment is made within ten days from the date of the invoice.

CASH FLOW - Cash receipts minus disbursements from a given asset, or group of assets, for a given period.

CASH FLOW STATEMENT - A statement similar to the typical statement of changes in financial position where the flows of cash, rather than working capital, are explained.

CASH SURRENDER VALUE OF LIFE INSURANCE - An amount equal to the amount that could be realized if the policy were canceled and traded with the insurance company for cash. This amount is not the same as the face value of the policy.

CASUALTY LOSSES are defined, for Medicare reimbursement purposes, as the complete or partial destruction of property resulting from an identifiable event of a sudden, unexpected or unusual nature, e.g., a hurricane, tornado, storm, fire, flood, accident, earthquake, vandalism, etc.

CERTIFIED FINANCIAL STATEMENT - A financial statement attested to by an independent public auditor who is a CPA.

CERTIFIED PUBLIC ACCOUNTANT (CPA) - An accountant who has satisfied the statutory and administrative requirements of his jurisdiction to be registered or licensed as a public accountant. In addition to passing the Uniform CPA Examination administered by the AICPA, the CPA must meet certain educational and moral requirements that differ from jurisdiction to jurisdiction. The jurisdictions are the fifty States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

CHAIN DISCOUNTS are a series of discount percentages. For example, if the chain discount is ten percent and five percent, then the actual cost is computed by reducing the list price by ten percent, then reducing the resulting balance by five percent.

CHAIN ORGANIZATION - Consists of a group of two or more health care facilities which are owned, leased, or controlled by one organization. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations which are engaged in other activities not directly related to health care.

CHARGE - As a noun, a debit to an account; as a verb, to debit.

CHARGE OFF to treat as a loss or expense an amount originally recorded as an asset.

CHARITY ALLOWANCES are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient.

CHARGE OF ACCOUNTS - A list of names and numbers of accounts systematically organized.

CLOSE means to transfer the balances in revenue and expense accounts directly, or through an income summary account, to a proprietorship account. It also refers to the transfer of purchase discounts to the related purchase account.

CLOSING ENTRIES are the entries that accomplish the transfer of revenue and expense accounts to the related balance sheet accounts.

COINSURANCE - Insurance policies that protect against hazards such as fire or water damage often specify that the owner of the property may not collect the full amount of insurance for a loss unless the insurance policy covers at least some specified percentage, usually about 80 percent, of the replacement cost of the property. Coinsurance clauses induce the owner to carry full, or nearly full, coverage.

COLLATERAL - Assets pledged by a borrower that will be given up if the loan is not paid.

COMBINATION METHOD - (NOTE: Effective July 1, 1979, the Combination Method of apportionment was eliminated as an acceptable method to determine allowable costs.) Under the Combination Method, Medicare's share of the cost of ancillary services was determined on the ratio of total Medicare charges to total charges to all patients for such services. The ratio was applied to the total cost of ancillary services.

The cost of routine services for Medicare patients was determined on the basis of a separate average cost per diem for general routine patient care plus a separate average cost per diem for each special care inpatient hospital unit.

Hospitals with less than 100 beds and all skilled nursing facilities and any hospital-skilled nursing facility complex with less than 100 beds were required to use the Combination Method.

COMMON OWNERSHIP exists when an individual or individuals have significant ownership or equity in the provider and the institution or organization serving the provider.

COMMON STOCK - Stock representing the class of owners who have residual claim on the assets and earnings of a corporation after all debts and preferred stockholders' claims have been met.

COMPARATIVE STATEMENTS - Financial statements showing information for the same company for different times, usually for two successive years.

CONSISTENCY - Treatment of like transactions in the same way in different periods so that financial statements will be more comparable than otherwise. This reporting policy implies that procedures, once adopted, should be followed from period to period.

CONSTRUCTIVE RECEIPT refers to an item that should be included in taxable income even though the cash has not been received because the taxpayer can control the timing of the receipt. For example, interest added to principal in a savings account is deemed to be constructively received.

CONTINGENT LIABILITY - A potential liability, if a certain event were to occur such as losing a lawsuit, a liability would be recognized. Until the outcome is known, the contingency is merely disclosed in notes rather than shown in the financial statements.

CONTROL exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institute.

CORPORATION - A legal entity authorized by a State to operate under the rules of the entity's charter.

COST is often used informally to mean the acquisition price of goods or services. (See Expense)

COST APPORTIONMENT refers to methods used to allocate costs in proportion to the relative number of days used by Medicare patients and other patients on the basis of the number of days used; or on the basis of charges to Medicare patients to charges to all patients.

COST CENTER - A division, a department, or subdivision thereof, a group of services or employees or both, or any unit or type of activity into which functions of an institution are divided for purposes of cost assignment and allocations.

COST FINDING may be defined as the allocation of the costs of the general service departments to each other and to the revenue producing departments. The bases for allocation are statistical data that measure the amount of service rendered by each cost center to the other cost centers.

The purpose of cost finding is to determine the total costs of operating each department (cost center) and, of course, the total cost of operating the hospital (or other provider).

COSTS NOT RELATED TO PATIENT CARE - Are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. They include, for example, costs of meals sold to visitors, costs of drugs sold to other than patients, cost of operation of a gift shop, and similar items.

COSTS RELATED TO PATIENT CARE - Includes all necessary and proper costs which are appropriate in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care usually include costs such as depreciation, interest expense, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, normal standby costs and others.

COURTESY ALLOWANCES - Are reductions in charges by the provider in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the provider, for services received from the provider. Reductions in charges made as employee fringe benefits, such as hospitalization and personnel health programs are not considered courtesy allowances.

CREDIT CARD COSTS are charges made by credit card organizations to a provider for the use of the credit card.

CREDITOR - One who lends.

CURRENT ASSET - An asset whose future benefit can or will occur within a short time, usually one year. Current assets include cash, marketable securities, receivables, inventory, and current prepayments.

CURRENT COST - Cost valued in current market prices or terms rather than in acquisition cost terms.

CURRENT LIABILITY - A debt or other obligation that must be discharged within a short time, usually one year.

CUSTOMARY CHARGE - Is the amount which best represents the actual charges made for a given medical service by the physician to his patients in general.

DEBENTURE BOND - A bond not secured with collateral.

DEBTOR - One who borrows.

DECLINING-BALANCE DEPRECIATION is the method of calculating the periodic depreciation charge by multiplying the book value at the start of the period by a constant percentage. Salvage value is not considered in computing the depreciation allowance under the declining balance method. However, under this method the asset should not be depreciated below the estimated salvage value.

DEDUCTIBLE AND COINSURANCE (CO-PAY) AMOUNTS are amounts payable by beneficiaries for covered services received from providers of services, excluding medical and surgical services rendered by physicians and surgeons. These deductibles and coinsurance (co-pay) amounts, including the blood deductible, must relate to inpatient hospital services, post-hospital skilled nursing facility care services, home health services, outpatient services, and medical and other health services furnished by a provider of services.

DEFALCATION - Embezzlement.

DEFERRED CHARGE is an expenditure not recognized as an expense of the period when made but is carried forward as an asset to be written off in future periods, such as for rent or insurance premiums.

DEFERRED COMPENSATION - Refers to salaries or wages or other compensation which is currently earned by an employee but which is not received until a future period, usually after retirement. Accordingly, a deferred compensation plan defers the receipt of income beyond the year in which it is earned.

A DEFERRED COMPENSATION PLAN must be formal, established and maintained by the provider and communicated to all eligible employees. A formal plan is one that is provided for in a written agreement executed between the provider and the participating employees, which promises to pay deferred amounts to eligible employees when due.

DEFICIT - A debit balance in the Retained Earnings account, usually due to an accumulation of losses over the period or periods.

DEPARTMENTAL METHOD - Medicare's share of the cost of each ancillary department is determined by finding the ratio of total charges to all patients in that particular department. The ratio is then applied to the total cost in that department. The total costs of each ancillary department, e.g., laboratory, radiology, operating room, etc., are added to find the total ancillary cost.

The cost of routine services is determined by multiplying the number of Medicare inpatient days by the average cost per day (average per diem cost). A separate computation is made for each special care unit in the hospital, e.g., coronary care unit, intensive care unit, burn unit, etc., using the applicable average cost per day for each special care unit.

The cost of the total routine services, including the cost of special care units, is added to the total cost for ancillary services to find the total operating cost of the provider.

DEPLETION - Exhaustion or amortization of a wasting asset, or natural resource.

DEPRECIATION is defined by the American Institute of Certified Public Accountants as a "...system of accounting which aims to distribute the cost or other basic value of tangible capital assets, less salvage value, over the estimated useful life of the assets in a systematic and rational manner. It is a process of allocation of costs, not of valuation."

But in nonaccounting language, depreciation is the decrease in value of assets used in the business due to wear or obsolescence. Because it is not practical to measure exactly how much of a decrease in value occurred each year, the amount of depreciation is usually deducted uniformly over the life of the asset.

DEPRECIABLE LIFE of an asset is its expected useful life to the provider; not necessarily the inherent useful or physical life of the asset. The useful life is determined in the light of the provider's experience and general nature of the asset and other pertinent data. Some factors for consideration are: (a) normal wear and tear, (b) obsolescence due to normal economic and technological advances, (c) climatic and other local conditions, and (d) providers' policy for repairs and replacement.

DEVELOPING HMOs - A Health Maintenance Organization (HMO) which has less operating experience than a mature HMO but has a reasonable prospect of meeting the qualifications for mature status within three years of its initial contract. Reimbursement to developing HMOs may be made only on a reasonable cost basis.

DIRECT COST - Cost of direct material, direct labor, and variable overhead incurred in producing a product.

DIRECT LABOR (MATERIAL) COST - Cost of labor (material) applied and assigned directly to a product.

DISBURSEMENT - Payment by cash or by a check.

DISCOUNT - In the context of compound interest, bonds, and notes, the difference between face or future value and present value of a payment. In the context of sales and purchases, a reduction in price granted for prompt payment of a debt.

DIVIDEND - A distribution of earnings to owners of a corporation; it may be paid in cash (cash dividend), with stock (stock dividend), with property, or with other securities. Dividends, except stock dividends, become a legal liability of the corporation when they are declared.

DOLLAR AMOUNTS OF SERVICE BASES are used where services rendered by a department or cost center involve distribution of supplies for which either the purchase price or the amount charged to patients is known or can be determined, e.g., for distributing medical supplies or drugs.

DONATED ASSET - An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or services.

When a provider makes any payment in acquiring the asset, then this payment, and not the fair market value, is considered to be the historical cost of the asset.

DOUBLE ENTRY - The system of recording transactions that maintains the equality of the accounting equation; each entry records equal debits and credits.

E

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT SERVICES (EPSDT) means screening and diagnostic services to determine physical or mental defects in indigent recipients under age 21. EPSDT also includes health care, treatment, and other measures to correct any defects and chronic conditions discovered.

ENTITY - A person, partnership, corporation, or other organization.

EQUITY CAPITAL is the owner's equity, sometimes called net worth. For Medicare reimbursement, equity capital includes the provider's investment in plant, property and equipment related to patient care, (net of depreciation.) It also includes the provider's net working capital maintained for necessary and proper operation of the patient care activities.

EXPAND - To increase the size of a provider's facility. This includes the purchase or construction of wings, departments, and/or buildings that will be included in a provider's existing certification.

EXPENDITURE - Incurring a liability or paying cash or relinquishing other funds to secure a goods for service.

EXPENSE refers to the cost of assets used up in producing revenue. Technically speaking, the word "cost" refers to an item that still has service potential and is an asset. The word "expense" is used after the asset's service potential has been used. In actual practice, however, "expense" and "cost" are used almost interchangeably.

EXPENSE ACCOUNT - An account to accumulate expenses; such accounts are closed at the end of the accounting period.

FACE AMOUNT (value) - The nominal amount due at maturity from a bond or note. The corresponding amount of a stock certificate is usually called the par or stated value, whichever is applicable.

FAIR MARKET VALUE means the value or price determined at arm's length between a willing buyer and a willing seller, each acting rationally in his own self interest.

FEASIBILITY ANALYSIS - Costs incurred by a provider in determining whether an area, or a site within the area, is suitable for a hospital or a skilled nursing facility. Such a service may be furnished to a provider by a franchisor or other organization that performs similar work.

FIDUCIARY - Someone responsible for the custody or administration of property belonging to another, such as an executor (of an estate), agent, receiver (in bankruptcy), or trustee (of a trust).

FINANCIAL STATEMENTS - The balance sheet, income statement, statement of retained earnings, and the statement of changes in financial position.

FISCAL AGENTS - See Fiscal Intermediaries.

FISCAL INTERMEDIARIES are generally Blue Cross Plans and commercial insurance companies which have contracted to handle the payment of claims on behalf of the Medicare program, using the principles of reimbursement and related guidelines. Fiscal intermediaries are nominated by hospitals, skilled nursing facilities, or home health agencies but must be approved to serve as fiscal intermediaries by the Secretary of HHS. The fiscal intermediaries are responsible for paying participating hospitals and other providers for the covered services received by Medicare patients. In addition to claims processing and payment, intermediaries furnish consultation services to providers in the development of accounting and cost-finding procedures to ensure the provider will receive equitable payment under the program.

FISCAL YEAR - A period of twelve consecutive months chosen by a business as the accounting period for annual reports. The fiscal year may or may not be a natural business year or a calendar year.

FIXED ASSETS - Plant assets.

FIXED COST (expense) - An expenditure or expense that does not vary with volume of activity, at least in the short run.

FIXED LIABILITY - Long term liability, longer than one year.

FRANCHISE - A privilege granted or sold, such as to use a name or to sell products.

FRANCHISE AGREEMENTS are usually as follows: In exchange for payment of various franchise fees, the franchisor generally provides a development package, including detailed information on the financing, building, and operation of a nursing home. Thus, the franchisor provides management planning, specialized development services, and continuing operational assist-

ance; while the franchise holder provides the investment, takes the risk, and carries the management responsibility of a private entrepreneur. The franchise holder also receives benefit of the national or regional reputation of the franchisor.

Generally, most of the services provided by a franchisor to an individual franchise holder relate to assistance in the initial phase of a facility's development. The services subsequently provided by the franchisor are, in comparison, of lesser scope. On the other hand, the fee payments to the franchisor are most substantial after the business is in operation, since under the usual franchise arrangement, a continuing percentage of gross revenues is paid to the franchisor for the life of the contract.

FRANCHISE FEES charged to a franchise-holder generally are:

1. A one-time payment for preliminary analysis (feasibility study) of the site under consideration. This fee is earned by a franchisor even where a franchise is not granted.
2. A one-time license fee when a license or franchise is granted, the amount of which is related to the size of the facility.
3. A continuing royalty fee, generally determined on the basis of a percentage of the gross revenues from routine services and percentage of gross revenues from ancillary services.
4. A fee related to territorial rights of a licensee to fully develop a specific area, sometimes including the right to issue sublicenses in the area.

FRANCHISE TAX is a periodic assessment levied by a State or local taxing authority on the operation of a business.

FRINGE BENEFITS are amounts paid to, or on behalf of, an employee, in addition to direct salaries or wages, and from which the employee or his beneficiary derives a personal benefit before or after the employee's retirement or death. Fringe benefits inure primarily to the benefit of the employee. However, there may also be some intrinsic benefit to the provider, such as increasing employee work efficiency and productivity, reducing personnel turnover, or increasing employee morale.

FUNCTION - In governmental accounting, said of a group of related activities for accomplishing a service or regulatory program for which the governmental unit is responsible.

FUND - An asset or group of assets set aside for a specific purpose.

FUND BALANCE - In governmental accounting context, the excess of assets of a fund over its liabilities and reserves; the not-for-profit equivalent of stockholders' equity.

FUNDED - Said of a pension plan or other obligation when funds have been set aside for meeting the obligation when it becomes due.

FUNDED DEFERRED COMPENSATION PLAN is one in which contributions are required to be systematically made to a funding agency for the purpose of meeting retirement benefits. For Medicare purposes, a funding agency is either a trustee, an insurance company, or a custodial bank account which provides for the accumulation of assets to be used for the payment of benefits under the deferred compensation plan.

FUNDING OF DEPRECIATION is the practice of setting aside cash, or other liquid assets, in a fund separate from the general funds of the provider to be used for replacement of the assets depreciated, or for other capital purposes. The deposits to the fund are generally in an amount equal to the depreciation expense charged into costs each year.

GAAP - Generally accepted accounting principles.

GAIN - Excess of revenues over expenses from a specific transaction.

GENERAL FUND - Assets and liabilities of a nonprofit entity not specifically earmarked for other purposes; the primary operating fund of a governmental unit.

GENERAL JOURNAL - The journal to record all transactions not recorded in specialized journals.

GENERAL LEDGER - The ledger containing all of the financial statement accounts. It has equal debits and credits as evidenced by the trial balance.

GENERALLY ACCEPTED ACCOUNTING PRINCIPLES (GAAP) - The conventions, rules, and procedures necessary to define accepted accounting practice at a particular time; includes both broad guidelines and relatively detailed practices and procedures.

GENERAL EXPENSES - Operating expenses other than those specifically assigned to cost of goods sold, selling, and administration.

GENERAL SERVICE COST CENTERS are operated for the benefit of the hospital as a whole. Each general service department may render services to other general service departments as well as to revenue producing departments. Examples of general service departments include housekeeping, dietary, maintenance, and supplies.

GOING CONCERN ASSUMPTION - For accounting purposes, a business is assumed to remain in operation long enough for all its current plans to be carried out.

GOODWILL - The excess of cost paid for an acquired firm or operating unit over the current or fair market value of net assets of the acquired unit. The term is sometimes used to indicate the value of good customer relations, high employee morale, a well-respected business name, and so on, which are expected to result in greater than normal earning power.

GROSS - Not adjusted or reduced by deductions or subtractions.

GROUP PRACTICE PREPAYMENT PLANS (GPPPs) - A Group Practice Payment Plan is a health plan which assumes the responsibility to provide comprehensive health maintenance and treatment services to its enrolled members. The enrolled members pay a predetermined, fixed fee periodically (usually monthly) whether or not they require or use any medical services. On the other hand, the fixed fee remains the same amount during the year regardless of the number or intensity of health services required or used by the enrolled member.

To supply the comprehensive health maintenance and treatment services, the GPPP makes formal arrangements with a number of physicians to provide certain services on a full time basis to the plan's members. The arrangements with the physicians are usually on a non-fee-for-service basis. In addition to

arrangements with full time physicians, many GPPPs make arrangements with other physicians on a part-time basis or on a fee-for-service basis, depending on circumstances and needs.

(See Health Maintenance Organizations, HMOs).

In general, the major difference between a GPPP and an HMO, under Medicare rules, is that a GPPP is required to furnish only Part B Medical services to its members, but an HMO is required to furnish both Part A provider services and Part B medical services to its members.

HEALTH MAINTENANCE ORGANIZATIONS (HMOs) - A Health Maintenance Organization is a health plan which assumes the responsibility to provide comprehensive health maintenance and treatment services to its enrolled members. The enrolled members pay a predetermined, fixed fee periodically (usually monthly) whether or not they require or use any medical services. On the other hand, the fixed fee remains the same amount during the year regardless of the number or intensity of health services required or used by the enrolled member.

To supply the comprehensive health maintenance and treatment services, the HMO makes formal arrangements with a number of physicians to provide certain services on a full-time basis to the plan's members. The arrangements with the physicians are usually on a non-fee-for-service basis. In addition to arrangements with full time physicians, many HMOs make arrangements with other physicians on a part time basis or on a fee-for-service basis, depending on circumstances and needs. (See Group Practice Prepayment Plans, GPPPs).

In general, the major difference between a GPPP and an HMO, under Medicare rules, is that a GPPP is required to furnish only Part B medical services to its members, but an HMO is required to furnish both Part A provider services and Part B medical services to its members.

HISTORICAL COST is the cost incurred by the present owner in acquiring the asset and to prepare it for use. Generally, such costs includes costs that would be capitalized under generally accepted accounting principles. For example, in addition to the purchase price, historical cost would include architectural fees, consulting fees, and related legal fees.

HOME OFFICES of chain organizations usually furnish central management and administrative services such as centralized accounting, purchasing, personnel services, management direction and control, and other services. To the extent the home office furnishes services related to patient care to a provider, the reasonable costs of such services are includable in the provider's cost report and are reimbursable as part of the provider's cost.

Where the home office of the chain provides no services related to patient care, neither the costs nor the equity capital of the home office may be recognized in determining the allowable costs of the providers in the chain.

HOSPITAL INSURANCE - (Part A of the Medicare Program) helps pay for services received when a Medicare patient is an inpatient in a hospital or in a skilled nursing facility, or when the patient is at home and receives services from a home health agency.

HYPOTHECATION means the pledging of property to secure a loan but without transfer of title or possession.

IMPROVEMENT - An expenditure to extend the useful life of an asset or to improve its performance (rate of output) over that of the original asset. Such expenditures are capitalized as part of the asset's cost.

IMPUTED COST - A cost that does not appear in accounting records, such as the interest that could be earned on cash spent to acquire inventories rather than, say, government bonds.

INCOME STATEMENT - The summary of revenues and expenses for the period.

INCOME TAX - An annual tax levied by the Federal and other governments on the income of an entity.

INCREMENTAL COST - Costs that will be incurred (saved) if an activity is undertaken (stopped).

INDIRECT COSTS - Costs of production not easily associated with the production of specific goods and services, i.e., overhead costs. Indirect costs may be allocated on some arbitrary basis to specific products or departments.

INDIRECT LABOR (MATERIAL) COST - An indirect cost for labor (material).

INDIVIDUAL PROPRIETORSHIP - Sole proprietorship.

INPATIENT DAY - A day of care rendered to any inpatient (except an individual occupying a bassinets for the newborn in the nursery).

INPATIENT ROUTINE NURSING SALARY COST DIFFERENTIAL was adopted as an allowable cost in 1969 in recognition of the fact that aged patients (65 and over) maternity patients, and pediatric patients (less than age 14), usually receive more inpatient routine nursing care than the other patients. This results in more costly care for the aged, maternity and pediatric patients on an average per day basis than the cost of care for the other patients. As a result, the Medicare program allowed a cost differential at the rate of eight and one-half percent.

INSOLVENT - Unable to pay debts when due. Said of a company even though assets may exceed liabilities.

INSURANCE - A contract for reimbursement of specific losses; purchased with insurance premiums. Self-insurance is not insurance but merely the willingness to assume risk of incurring losses while saving the premium.

INTANGIBLE ASSET - A nonphysical, noncurrent asset such as a patent, trademark, or goodwill.

INTEREST - The charge or cost for using money; frequently expressed as a rate per period, usually one year, called the interest rate.

INTERIM PAYMENTS are paid to providers monthly or more frequently based on a rate that approximates reasonable costs as practicable as possible. The purpose of interim payments is to maintain a cash flow to the provider during the cost reporting period.

INTERMEDIARIES - See Fiscal Intermediaries.

INTERMEDIARY HEARING is conducted by a hearing officer or a panel of officers designated by the intermediary to hear appeals concerning disputed reimbursement items.

INTERMEDIARY CARE FACILITY (ICF) is an institution licensed under State law to provide, on a regular basis, health care and services to individuals who do not require the degree of care and treatment which a hospital or a skilled nursing facility is designed to provide. The individuals must, however, require care and services above the level of room and board that can be made available only in institutional facilities. Federal payment for ICF care is limited to Medicaid.

INTERNAL CONTROL - The procedures carried out by management of a business to attempt to insure that operations are carried out or recorded as planned, especially in the context of cash transactions, often referred to as an internal check.

INTERPOLATION - The estimation of an unknown number intermediate between two (or more) known members.

INVESTMENT - An expenditure to acquire property or other assets in order to produce revenue. Investment also refers to the asset required, e.g., securities of other companies held for the long term.

INVOICE - A document showing the details of a sale or purchase transaction.

J

JOURNAL - The place where transactions are recorded as they occur.

JOURNAL ENTRY - A recording in a journal of equal debits and credits, with an explanation of the transaction, if necessary, to explain the transaction so recorded.

JOURNALIZE - To make an entry in a journal

K

L

LAND - An asset shown at acquisition cost plus the cost of any improvements not including buildings.

LEASE - A contract calling for the lessee (user) to pay the lessor (owner) for the use of an asset. A cancellable lease is one the lessee can cancel when he or she chooses. A noncancellable lease requires payments from the lessee for the life of the lease.

LEASEHOLD - The right of the lessee to use lease property.

LEASEHOLD IMPROVEMENT - An improvement to leased property. It should be amortized over service life of the property or the life of the lease, whichever is shorter.

LEASE-PURCHASE AGREEMENTS are essentially the same as installment purchases of facilities or equipment.

LIABILITY - Usually, a legal obligation to pay a definite amount at a definite time in return for a current benefit.

LIMITATION ON REIMBURSEMENT FOR CAPITAL EXPENDITURES excludes from Medicare reimbursement to providers, amounts for depreciation, interest, return on equity capital, and other costs related to expenditures for plant and equipment which 1) exceed \$100,000, or 2) change the bed capacity of the facility, or 3) substantially change the services provided by the facility, if the expenditures have not been approved by the State planning agency or are inconsistent with State or local health facility planning requirements.

LIMITATION ON THERAPY AND OTHER SERVICES FURNISHED BY OUTSIDE SUPPLIERS refers to limits set on amounts that can be paid to outside suppliers for physical therapy, occupational therapy, speech therapy and other therapies.

LIMITED INSURANCE COMPANIES (sometimes referred to as captive insurance companies), have been established by hospitals, or groups of hospitals, or hospital associations to insure themselves against malpractice losses.

LIQUID ASSETS - Cash, marketable securities, and sometimes receivables.

LIST PRICE - The published or nominally quoted price for goods.

LOCALITY - For the purpose of making physicians' reasonable charge determinations, a locality is the geographic area for which the carrier is to derive the prevailing charges for services. Usually a locality will be a political or economic subdivision of a State, and it should include a cross-section of the population with respect to economic and other characteristics. Where people tend to gravitate toward certain population centers to obtain medical care or service, localities may be recognized on a basis constituting medical service areas (interstate or otherwise), comparable in concept to "trade areas".

LOCK IN - Enrollees in a risk-basis HMO are "locked in" to receive services only from the HMO. No payments may be made to the beneficiary or on his or her behalf for any services which are not provided directly or through arrangements by the risk-basis HMO.

LONG-TERM - Due more than one year, hence - noncurrent.

LOSS - Excess of cost over selling price for a single transaction; negative income for a period.

LOWER OF COST OR CHARGES - For cost reporting periods beginning after December 31, 1973, payments to providers are made on the basis of the lower of reasonable cost or customary charges made by the provider to the general public for the same services, subject to certain cost limitations.

LUXURY ITEMS OR SERVICES are those that are substantially in excess of or more expensive than the usual items or services rendered within a provider's operation to the majority of patients.

MAINTENANCE - Expenditures made to preserve an asset's service potential for its originally-intended life.

MARKET BASKET INDEX is used to account for the impact of changing wage and price levels on hospital costs. The index was developed from the price of goods and services purchased by hospitals and is used in connection with cost limits on routine services.

MATERIAL - As an adjective, it means relatively important. As a noun, raw material.

MATERIALITY - The concept that accounting should disclose only those events that are relatively important for the business or for understanding its statements.

MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES (Title V) is a program designed to help each State to extend and improve services for reducing infant mortality, to improve the health of mothers and children, and to promote surgical, medical, corrective and other services for diagnosis, hospitalization and aftercare for children who are crippled or suffering from conditions leading to crippling.

MATERNITY DAY - Means a day of care rendered to a female inpatient admitted for delivery of a child.

MATURE HMO is an HMO which has had enough operating experience to be eligible for risk-basis payments under Medicare.

MATURITY - The date at which an obligation, such as the principal of a bond or note, becomes due.

MAXIMUM ALLOWABLE COST LIMITATION - Called the "MAC" for a particular drug, is based on the lowest unit price at which the drug is widely and consistently available to pharmacists in the most frequently purchased package size.

MEDICAID (TITLE XIX) is an assistance program. It pays medical bills for the needy and low income people who are aged, blind, disabled, or members of families with dependent children. Medicaid is a Federal-State partnership and varies from State to State. Each State designs its own Medicaid program within Federal guidelines. Medicaid is financed jointly with State and Federal funds.

MEDICAL INSURANCE (Part B of the Medicare Program) helps pay for doctors' services, outpatient hospital services, outpatient physical therapy, speech therapy or other therapies, home health services, and many other health services not covered by hospital insurance.

MEDICALLY INDIGENT - People who are not financially indigent but who cannot meet the catastrophic costs of a major medical expense.

MEDICARE (TITLE XVIII) is a health insurance program for persons aged 65 and over. Medicare (Part A) pays for care in hospitals, skilled nursing facilities (nursing homes), and related health institutions, financed through contributions from employers and employees through the Social Security system. Medicare (Part B) pays for physicians' care and other health services, financed through monthly insurance premiums is matched by a Federal contribution.

Medicare is a Federal program and is the same all over the United States.

MERGER - The joining of two or more unrelated businesses into a single legal entity.

MORTGAGE - A claim given by the borrower (mortgagor) to the lender (mortgagee) against the borrower's property in return for a loan.

MOVING AVERAGE - An average computed on observations over time. As a new observation becomes available, the oldest one is dropped so that the average is always computed for the same number of observations and only the most recent ones.

MUNICIPAL BOND - A bond issued by a village, town, city, county, or State. Interest on such bonds is generally exempt from Federal income taxes.

MULTIPLE-FACILITY-COMPLEX PROVIDERS are hospitals with hospital-based skilled nursing facilities (SNFs) or with hospital-based home health agencies (HHAs).

NATURAL BUSINESS YEAR - A twelve month period chosen as the reporting period so that the end of the period coincides with a low point in activity or inventories.

NET - Reduced by all relevant deductions.

NET ASSETS - Ownership equity; total assets minus total liabilities.

NET INCOME - The excess of all revenues and gains for a period over all expenses and losses of the period.

NET LOSS - The excess of all expenses and losses for a period over all revenues and gains of the period.

NET WORTH - Owner's equity.

NEW PROVIDER is a provider of inpatient services which has operated as the type of provider for which it is certified for Medicare, under present and previous ownership, for less than three full years.

NONPAID WORKERS - Sisters and other members of a religious order often perform duties which are usually performed by lay workers in other hospitals. These duties, primarily in the administrative and nursing areas, are performed without payment of salaries or wages.

The value of services performed by nonpaid workers who work more than 20 hours per week in various types of full-time positions that are normally occupied by paid personnel of providers not operated by or related to religious orders is allowable in reimbursable costs as an operating expense. Such amounts must be identifiable in the records of the institutions as a legal obligation.

NONPROFIT CORPORATION - An incorporated entity with no owners who share in the earnings. Such corporations usually emphasize providing services rather than maximizing income.

NONPRIVATE PATIENT is one who had no prior relationship with any of the physicians prior to admission.

NONVISITING COSTS OF HOME HEALTH AGENCIES - Nonvisiting costs are costs related to activities of the home health agency other than home visiting or visits by the patients as an outpatient to a hospital, skilled nursing facility, rehabilitation center, or outpatient department affiliated with a medical school for covered home health services. Nonvisiting costs include costs incurred for the operation of school visit programs, meal-on-wheels programs, well-baby clinics, etc. These costs are not allowable under Medicare.

NORMAL STANDBY COSTS means having enough extra beds, equipment, supplies, and nursing staff and other staff to take care of unexpected emergencies or a greater number of patients than usual. Medicare will reimburse providers for such "normal" extras, but it will not reimburse a provider which claims that an entire unoccupied floor or wing is used for standby purposes.

NOTE - An unconditional written promise by the maker (borrower) to pay a certain amount on demand or at a certain future time.

NOTICE OF PROGRAM REIMBURSEMENT (NPR) is sent to a provider explaining the adjustments made by the intermediary, the final adjusted amounts and the amount of overpayment or underpayment.

NURSERY DAY means a day of care rendered to an inpatient occupying a bassinet for the newborn in the nursery.

OBSOLESCENCE means a decline in market value, or a reduction in the estimated service life, of an asset caused by improved equipment or other alternatives becoming available that will be more cost effective. The decline in market value or service life is not related to physical changes in the asset itself.

OFFSHORE CAPTIVES refers to captive insurance companies which are not in the United States.

OPERATING - An adjective used to refer to revenue and expense items relating to the company's main lines of business.

OPERATING EXPENSE - Expenses incurred in the course of ordinary activities of an entity.

ORGANIZATION COSTS - Are those costs directly incident to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organization costs extend over more than one accounting period and thus affect the costs of future periods of operation.

ORIGINAL COST - Acquisition cost.

OVERHEAD COSTS - Any cost not specifically associated with the production of identifiable goods and services.

OWNERS' EQUITY - In a sole proprietorship, it is the difference between assets and liabilities. In a corporation, it is the paid-in capital plus retained earnings. In a partnership, it is the partners' capital accounts.

PARTNERSHIP - Contractual arrangement between individuals to share resources and operations in a jointly run business.

PAST SERVICE COST - Present value at a given time of a pension plan's unrecognized, and usually unfunded, benefits assigned to employees for their service before the inception of the plan.

PEDIATRIC DAY means a day of care rendered to an inpatient less than age 14 who is not occupying a bassinet for the newborn in the nursery.

PENSION FUND is the portion of the pension cost accumulated in the hands of an organization, individual, or trust to be used for the purpose of meeting retirement benefits when they become due.

In order for a plan to be considered funded for purposes of Medicare cost reimbursement, the liability to be funded must have been determined, and the provider must be obligated to make payments into the fund. Funds existing at the discretion of the provider are not considered valid.

PENSION PLAN is a type of deferred compensation plan which is established and maintained by the employer to provide systematically for the payment of definitely determinable benefits to its employees usually over a period of years, or for life, after retirement. Such a plan may include disability, withdrawal, option for lump-sum payment, or insurance or survivorship benefits incidental and directly related to the pension benefits. Such benefits are generally measured by and are based on such factors as age of employees, years of service, and compensation received by the employees.

PER DIEM is an interim payment to providers based on an estimate of the cost of rendering services on a per day (per diem) basis.

PERCENTAGE OF CHARGES is an interim payment to providers based on a predetermined percentage of the charges made to Medicare patients, e.g., 85 percent of the charges, or 90 percent of the charges. The predetermined percentage is based on the ratio between cost and charges in the hospital.

PERIODIC INTERIM PAYMENT (PIP) is an interim payment to providers based on dividing the estimated total cost for the year into regular periodic payments, usually 26, payable in equal amounts on a regular day every other week.

PLANNING COSTS include feasibility studies, engineering studies, architect fees, finder's fees, etc., and usually involve the provider's staff or the use of outside consultants. Planning costs generally become part of the historical cost of a completed facility.

PLANT - Plant assets.

PLANT, PROPERTY AND EQUIPMENT - Includes buildings, land, fixtures and equipment, goodwill, and other assets not part of current assets.

POOLED COSTS refers to the remaining costs or "pool" incurred for general management or administrative services which cannot be allocated on a functional basis. The pooled costs are allocated on bases such as inpatient days or total costs or other appropriate bases.

PREPAYMENT refers to deferred charges. Rent and insurance premiums paid in advance are usually classified as current prepayments.

PRIME COST - Sum of direct materials plus direct labor costs assigned to product.

PRINCIPAL - An amount on which interest is charged or earned.

PRINCIPLE - See generally accepted accounting principles.

PREVAILING CHARGES for physicians are those charges which fall within the range of charges that are most frequently and widely used in a locality for a particular procedure or service. The top of this range establishes an overall limitation on the charges which the carrier should accept as a reasonable for a given procedure or service, except where unusual circumstances or medical complications warrant an additional charge.

For any fiscal year, the prevailing charge limit in a locality for a service must be calculated at the 75th percentile of the customary charges determined for that service. In this calculation, each customary charge for the service is arrayed in ascending order and weighted by how often the physician or other person rendered the service (as reflected by the charge data the carrier used to calculate the customary charge). The lowest customary charge which is high enough to include the customary charges of the physicians or other persons who rendered 75 percent of the cumulative services is then determined to be the prevailing charge for the service.

PRIOR SERVICE COST - Present value at a given time of a pension plan's unrecognized benefits assigned to employees for their service before that given time. (See Past Service Cost)

PRIVATE PATIENT is one who has had a doctor-patient relationship with the attending physician prior to admission.

PROFESSIONAL COMPONENT of a provider-based physician's service pertains to that part of the physician's activities which is directly related to the medical care of the individual patient. It represents compensation for the identifiable medical services by the physician which contribute to the diagnosis of the patient's condition or to his or her treatment.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSROs) consisting of substantial numbers of practicing physicians (usually 300 or more) in local areas, assume responsibility for comprehensive and ongoing review of services covered under the Medicare, Medicaid, and Maternal and Child Health programs.

The purpose of these organizations, as stated in the law, is "to promote the effective, efficient, and economical delivery of health care services of proper quality for which payment may be made...".

PROFIT - Excess of revenues over expenses for a transaction.

PROFIT AND LOSS STATEMENT - Income statement.

PROMISSORY NOTE is an unconditional written promise to pay a specified sum of money on demand or at a specified date.

PRORATE - To allocate in proportion to some base; for example, to allocate service department costs in proportion to hours of service used by the benefited departments.

PROPRIETARY PROVIDERS means providers which operate with the expectation of earning profit for the owners, as distinguished from providers operating on a nonprofit basis. Proprietary providers may be sole owners, partners, or corporations.

PROVIDER-BASED PHYSICIANS are physicians employed or retained by providers on a full-time basis, usually in the fields of pathology, physiatry, anesthesiology, and radiology. The provider-based physicians may be engaged in teaching, administration, supervision of professional or technical personnel, etc., as well as providing direct medical services to individual patients.

PROVIDER COMPONENT of a provider-based physician's services represents that portion of the physician's services which is not directly related to an identifiable part of the medical care of the individual patient. Provider services include teaching, research conducted in conjunction with and as part of patient care, administration, general supervision of professional or technical personnel, laboratory quality control activities, committee work, performance of autopsies, and attending conferences as part of the physician's provider services activities. Reimbursement for such services are made on a reasonable cost basis under Part A where they relate to inpatient services. Reimbursement is under Part B for outpatient services and for certain inpatient ancillary services where Part A coverage has been exhausted.

PROVIDERS OF SERVICES (usually referred to as provider) - A provider of services means a hospital, skilled nursing facility (SNF), home health agency (HHA) and, for the limited purpose of furnishing outpatient physical therapy or speech pathology services, a clinic, rehabilitation agency or public health agency.

PROVIDER REIMBURSEMENT REVIEW BOARD (PRRB) is a review board to which disputed items in reimbursement are appealed. The hearing is conducted by the PRRB whose members are appointed by the Secretary of HHS.

PRUDENT BUYER PRINCIPLE means to pay not more than the going price for an item or service, and to take advantage of any discounts available through bulk purchases or other bargaining leverage. The prudent buyer economizes by minimizing cost whenever he or she can do so.

PURCHASE DISCOUNTS - Within the meaning of this principle include cash, trade and quantity discounts.

QUALIFIED REPORT (opinion) - Auditor's report containing a statement that the auditor was unable to complete a satisfactory examination of all he or she thinks relevant or that he or she has doubts about the financial impact of some item reported in the financial statements.

QUANTITY DISCOUNTS are reductions from list prices granted because of the size of individual or total purchases.

QUANTITY OF SERVICE BASES make use of actual counts or reasonable estimates of the amount of service rendered by a department or cost center, e.g., the number of meals served, or the number of pounds or pieces of laundry processed, or the number of hours spent in a nursing unit.

RATIO - The number resulting when one number is divided by another. Ratios are used to determine the relationship in quantity, amount, or size between two or more things.

RCCAC METHOD (OR RCC METHOD) means the ratio of charges applied to costs. For example, if the total charges for a hospital department were \$100,000, of which \$40,000 was charged to aged patients and \$60,000 was charged to other patients, it can be assumed that the aged patients used 40 percent of the services. It follows, therefore, that the aged patients were responsible for 40 percent of the cost of that department.

The RCC method can be used to find the ratio of total Medicare charges to the total charges of a hospital; this is called Gross RCC.

The RCC method can also be used to find the ratio of Medicare charges to total charges in each department of a hospital; this is called Departmental RCC.

REASONABLE CHARGES (of physicians) - The two criteria set out in the Medicare law (Section 1842 of Title XVIII) which must be considered in determining the reasonable charge for a service are: (a) the customary charges for similar services generally made by the physician or other person furnishing such services; and (b) the prevailing charges in the locality for similar services. Therefore, the reasonable charge for a specific service may not exceed the lowest of: (a) the physician's or other person's customary charge for that service; (b) the prevailing charge made for similar services in the locality; or (c) the actual charge of the physician or other person rendering the service.

The income of the individual patient may not be considered in determining the amount of the reasonable charge. Consideration of a patient's income in determining the reasonable charge could be looked upon as an inverse means test -- that is, it would result in a situation under which the Medicare program would pay more for beneficiaries with high incomes than it would pay for beneficiaries with low incomes. There is no provision in the Medicare law for a carrier to evaluate the reasonableness of charges in light of an individual beneficiary's economic status.

REASONABLE COST takes into account all costs of providers, both direct and indirect, including normal standby costs. The objective is that under the methods of determining costs, "the costs with respect to individuals covered will not be borne by others not so covered, and the costs with respect to individuals not so covered will not be borne by the program".

REBATES represent refunds of a part of the cost of goods or services. A rebate is commonly based on the total amount purchased from a supplier, and differs from a quantity discount in that it is based on the value of purchases, whereas quantity discounts are generally based on the quantity purchased.

REBUILD - To make extensive improvements; to restore to a previous state; to make extensive changes, to remodel; to tear down an existing provider's facility and build a new facility in the immediate proximity of the old facility.

RECOVERY OF BAD DEBTS - See Bad Debt Recovery.

REFUNDS are amounts paid back by the vendor generally in recognition of damaged shipments, overpayments, or returned purchases. (Refunds of container deposits are not purchase refunds under this definition.)

RELATED TO THE PROVIDER means that the provider to a significant extent is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies.

A RELATIVE VALUE SCHEDULE (RVS) - Is based on assigning a numerical value to a medical or surgical procedure, relative to some basic procedure. (See Chapter 23 for a detailed explanation and example).

RELOCATE - To move an existing provider to a new location and close the old provider.

RENT - A charge for the use of land, buildings, or other assets.

REPORT - Financial statement; auditor's report.

RESEARCH means a systematic, intensive study directed toward a better scientific knowledge of the science and art of diagnosing, treating, curing and preventing mental or physical disease, injury, or deformity; relieving pain; and improving or preserving health. Research may be conducted at a laboratory bench without the use of patients or it may involve patients. Furthermore, there may be research projects that involve both laboratory bench research and patient care research.

RESERVE METHOD is used to estimate the amount of bad debts which may be incurred during a cost reporting period. The amount estimated as bad debts is set up as a reserve account. The amount set up does not represent any specific debt but is usually based on a percentage of the total accounts receivable.

RESTRICTED OR DESIGNATED grants, gifts, and income from endowments are funds, cash or otherwise, which must be used only for a specific purpose designated by the donor.

REVENUE PRODUCING COST CENTER is defined as a department or groups of services for which the patient is billed as a separate item when he receives these services. Examples include radiology, operating room, laboratory, and out-patient clinics.

RISK-BASIS HMO refers to an HMO which contracts with the Medicare program on an incentive, or risk, basis. Savings of up to 20 percent of the Adjusted Average Per Capita Cost are shared equally between the HMO and the Medicare program.

ROUTINE SERVICE - Sometimes referred to as the "room and board" charge are those services included by the provider in a daily service charge. Included in routine services are the patient's room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

SALARY - Compensation paid to managers, administrators, professionals, and the like.

SALE - a revenue transaction where goods or services are delivered to a customer in return for cash or a contractual obligation to pay.

SALE AND LEASEBACK - A financing transaction where improved property is sold but is taken back for use on a long term lease. Such transactions often have advantageous income tax effects.

SALES ALLOWANCE - A reduction in sales invoice price usually given because the goods received by the buyer are not exactly what was ordered.

SALES DISCOUNT - A reduction in sales invoice price usually offered for prompt payment.

SALVAGE VALUE is the estimated amount expected to be realized upon the sale or other disposition of the depreciable asset when it is no longer useful to the provider. The amount is ordinarily estimated at the time of acquisition and deducted from the cost of the depreciable property to arrive at the basis for depreciation.

SCRAP VALUE - Salvage value.

SEC - Securities and Exchange Commission, an agency authorized by the U. S. Congress to regulate, among other things, the financial reporting practices of most public corporations.

SEED MONEY GRANTS are made to cover specific operating costs for services for a stated period of time. During this time, the provider is expected to develop sufficient patient caseloads to enable continued self-sustaining operation.

SELF INSURANCE - See Insurance.

SERVICE DEPARTMENT - A department providing services to other departments.

SERVICES UNDER ARRANGEMENTS - Providers may furnish services under arrangements with outside suppliers, including other providers. For example, many providers arrange to have physical therapy, respiratory therapy or speech therapy furnished to patients by outside suppliers. Other providers may make arrangements for ambulance services with an outside supplier, and some providers which do not have their own pharmacy purchase drugs under arrangements with local pharmacies.

The amount charged by the supplying organization and paid by the provider for the services rendered then becomes a cost to the provider. This amount is includable in the provider's allowable costs for Medicare purposes to the extent that the costs of such purchased services are determined to be reasonable.

SHORT-TERM - Current; ordinarily, due within one year.

SIMPLE INTEREST - Interest calculated on the original principal only. Interest earned during the period of the loan is neither added to the principal nor paid to the lender.

SINKING FUND - Assets and their earnings earmarked for the retirement of bonds or other long-term obligations.

SOLE COMMUNITY HOSPITAL is a hospital which is the sole source of hospital care in its area because of its isolated location or absence of other hospitals.

START-UP COSTS refers to the costs a provider incurs prior to the time the first patient is admitted for treatment. Because these start-up costs are related to patient care services which will not be rendered until the institution is opened, they must be capitalized as deferred charges and amortized over a number of benefiting periods.

STATEMENT OF FINANCIAL POSITION - Balance sheet.

STOCKHOLDER SERVICING COSTS are costs incurred primarily for the benefit of stockholders or other investors, but are not related to patient care. These include, but are not limited to:

- (1) the costs of stockholders' annual reports and newsletters,
- (2) annual meetings,
- (3) mailing of proxies,
- (4) stock transfer agent fees,
- (5) stock exchange registration fees,
- (6) stockbroker and investment analysis, and
- (7) accounting and legal fees for consolidating statements for SEC purposes.

STRAIGHT-LINE METHOD - Under the straight-line method, the annual amount for depreciation is computed by dividing the cost of the asset less any estimated salvage value by the years of useful life. This method produces a uniform depreciation allowance each year.

$$\frac{\text{Cost of asset less salvage value}}{\text{Number of years of useful life}} = \begin{array}{l} \text{Annual} \\ \text{allowance for} \\ \text{depreciation} \end{array}$$

SUM-OF-THE-YEARS' DIGIT METHOD - Under the sum-of-the-years' digit method, the annual depreciation allowance is computed by multiplying the cost of the asset less estimated salvage value by a constantly decreasing fraction.

The numerator of the fraction represents the remaining years of useful life of the asset at the beginning of each year; the denominator represents the sum of the years of estimated useful life at the time the asset was acquired.

(example follows)

<u>Example:</u>	Cost of new asset	\$17,000
	Salvage value	2,000
	Estimated useful life	5 years

Computation:

Add the sum of the years of useful life
 5 years = 1+2+3+4+5 = 15
 15 is the denominator of the fraction

For the numerator in each year, use the remaining years of useful life including the year for which depreciation is taken. This means using each number in the sum of the years of useful life in reverse order, 5 for the first year, 4 for the second year, 3 for the third year, etc.

Cost of asset	\$17,000
Salvage value	<u>2,000</u>
Basis for depreciation	\$15,000

<u>Year</u>	<u>Basis for Depreciation</u>		<u>Fraction</u>	<u>Annual Depreciation</u>
1	\$15,000	x	5/15	\$5,000
2	\$15,000	x	4/15	4,000
3	\$15,000	x	3/15	3,000
4	\$15,000	x	2/15	2,000
5	\$15,000	x	1/15	1,000

SUPPLEMENTAL SECURITY INCOME (SSI) is a Federal income maintenance program for the aged, blind, and disabled in the 50 States, the District of Columbia, and the Northern Mariana Islands. The SSI program provides a floor of income for the aged, blind, and disabled people who have little or no income and resources. The SSI payments, in most cases, supplement whatever income may be available from other sources including social security benefits.

SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND is the fund in which the premium payments for the Part B program of Medicare are deposited.

TEACHING HOSPITALS - In teaching hospitals, interns and residents receive training in the delivery of medical care to patients under the supervision of teaching physicians.

In nonteaching hospitals, physician services are usually delivered by an individual physician to an individual patient. In teaching hospitals, however a team of interns and residents and attending physicians care for patients, in the course of which the interns and residents receive their education and training.

TEACHING PHYSICIAN - The teaching physician provides graduate medical education and patient care in the teaching hospital. The teaching physician is a fully trained physician who is responsible for, or is directly engaged in, patient care activities and is also responsible for the instruction and supervision of interns and residents.

TERMS OF SALE refers to the conditions governing payment of a sale. For example, the terms 2/10 , net/30 mean that if payment is made within ten days of the invoice date, a discount of two percent from invoice price can be taken; the invoice amount must be paid, in any event, within thirty days or it becomes overdue.

TITLE V, MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES is a program designed to help each State to extend and improve services for reducing infant mortality; to improve the health of mothers and children; and to promote surgical, medical, corrective and other services for diagnosis, hospitalization and aftercare for children who are crippled or suffering from conditions leading to crippling.

TITLE XVIII, MEDICARE is a health insurance program for persons aged 65 and over. Medicare (Part A) pays for care in hospitals, skilled nursing facilities (nursing homes) and related health institutions, financed through contributions from employers and employees through the Social Security system. Medicare (Part B) pays for physicians' care and other health services, financed through monthly insurance premiums paid voluntarily by enrollees in the Medicare program. The voluntary premium is matched by a Federal contribution. Medicare is a Federal program and is the same all over the United States.

TITLE XIX, MEDICAID is an assistance program. It pays medical bills for needy and low income people who are aged, blind, disabled, or members of families with dependent children. Medicaid is a Federal-State partnership and varies from State to State. Each State designs its own Medicaid program within Federal guidelines. Medicaid is financed jointly with State and Federal funds.

TRADE DISCOUNT is a discount from list price offered to all customers of a given type.

TREASURY STOCK - Capital stock issued and then reacquired by the corporation. Such reacquisitions result in a reduction of stockholders' equity, and are usually shown on the balance sheet as contra to stockholders' equity. Neither gain nor loss is recognized on transactions involving treasury stock.

TRIAL BALANCE - A listing of account balances; all accounts with debit balances are totalled separately from accounts with credit balances. The two totals should be equal. Trial balances are taken as a partial check of the arithmetic accuracy of the entries previously made.

UNADJUSTED TRIAL BALANCE - Trial balance before adjusting entries at end of period are made.

UNCONDITIONAL VESTING of benefits in a pension plan means that once a participant's benefits are vested in accordance with the normal vesting schedule, there are no conditions incorporated in the plan which would deprive the participant of such benefits.

UNRESTRICTED GRANTS, GIFTS, AND INCOME FROM ENDOWMENTS are funds, cash or otherwise, given to a provider without restriction by the donor as to their use.

UTILIZATION REVIEW - A Utilization Review plan must provide for:

- (1) Committee review of admissions, length of stays, ancillary services furnished (including drugs) and professional services furnished. The review could be made on a sample or other basis;
- (2) Notification to the patient and his attending physician in any case in which it is determined that admission to, or further stay in the institution is not medically necessary; and
- (3) Review of each case of continuous extended stay during the patient's confinement in the hospital or skilled nursing facility.

The utilization review plan has to be one that would enable the hospital or skilled nursing facility to maintain a high quality of patient care and use the hospital or SNF more effectively and efficiently.

VENDOR PAYMENT PROGRAM is one in which payments are made directly to the provider of service for care rendered to an eligible individual. The Medicaid program operates as a vendor payment program and providers must accept the Medicaid reimbursement as payment in full.

VESTED BENEFITS (in a pension plan) means that at the time the benefits become vested, the employee cannot lose any of the benefits in the fund; i.e., the benefits are not contingent on the employee's continuing services to the employer.

VISITING COSTS OF HOME HEALTH AGENCIES are incurred when a staff member of the home health agency, or others under arrangements made by the home health agency, make a personal contact to provide a covered home health service to a beneficiary in his place of residence. Visiting costs include all incurred costs related to making the visits, such as preparation for the visits, telephone calls or conferences about the patients, maintaining the patient's records, travel to the patients, and treating the patients.

Visiting costs also cover outpatient visits made by a patient to a hospital, skilled nursing facility, rehabilitation center, or outpatient department affiliated with a medical school to receive covered home health services which involve the use of equipment which cannot be made readily available to the patient in his place of residence.

VOUCHER is a document that serves to recognize a liability and authorize the disbursement of cash. It is sometimes used to refer to the written evidence documenting an accounting entry, as in the term journal voucher.

WAGE - Compensation of employees based on time worked or output of product for manual labor.

WAGE INDEX, developed from service industry wages, is used to adjust the wage portion of cost limits to reflect differing wage levels among the areas in which hospitals are located.

WAIVER OF LIABILITY PROVISION protects a Medicare patient from liability for payments to a provider for non-covered services (when the services are found to be not reasonable or necessary or to involve custodial care) when the patient did not know or could not reasonably be expected to have known that the services were not covered.

WARRANTY - A promise by a seller to correct deficiencies in products sold.

WEIGHTED AVERAGE means an average of the values of a set of items to which each is given a weight indicative of its relative importance or its frequency. The weighted average is computed by counting each occurrence of an item, not merely the number of different items as in the computation of a simple average.

Example: The following items were purchased:

<u>Item</u>	<u>Quantity</u>	<u>Price Per Unit</u>	<u>Total Cost</u>
A	1	\$ 10.00	\$ 10.00
B	2	25.00	50.00
C	3	40.00	<u>120.00</u>
Totals	<u>6</u>		<u>\$180.00</u>

Weighted Average $\$180.00 \div 6 = \30.00

Simple Average $\$180.00 \div 3 \text{ (items)} = \60.00

WORKING CAPITAL is the difference between current assets and current liabilities. Net working capital means working capital from which has been subtracted any amounts which are in excess of the amount needed for the necessary and proper operation of patient care activities.

WORKING PAPERS - The schedules and analyses prepared by the auditor in carrying out investigations prior to issuing in opinion on financial statements.

WORK SHEET - A tabular schedule for convenient summary of adjusting and closing entries. The work sheet usually begins with a preclosing trial balance. Adjusting entries are shown in the next two columns, one for debits and one for credits. The horizontal sum of each line is then carried right into either the income statement or balance sheet columns, as appropriate.

X, Y, Z

WAGE - Compensation of employees based on time worked or output of product for manual labor.

WAGE INDEX, developed from service industry wages, is used to adjust the wage portion of cost limits to reflect differing wage levels among the areas in which hospitals are located.

WAIVER OF LIABILITY PROVISION protects a Medicare patient from liability for payments to a provider for non-covered services (when the services are found to be not reasonable or necessary or to involve custodial care) when the patient did not know or could not reasonably be expected to have known that the services were not covered.

WARRANTY - A promise by a seller to correct deficiencies in products sold.

WEIGHTED AVERAGE means an average of the values of a set of items to which each is given a weight indicative of its relative importance or its frequency. The weighted average is computed by counting each occurrence of an item, not merely the number of different items as in the computation of a simple average.

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X, Y, Z

Medicare Reference Chart 1966—1982

Part A—Hospital Insurance Deductible and Coinsurance Amounts ¹

FOR BENEFIT PERIODS BEGINNING IN	INPATIENT HOSPITAL ²			SKILLED NURSING FACILITY	HOME HEALTH AGENCY	Blood
	FIRST 60 DAYS	61ST THRU 90TH DAY	60 LIFETIME RESERVE DAYS (NON RENEWABLE)	21ST THRU 100TH DAY	UNLIMITED VISITS ³	
	DEDUCTIBLE	COINSURANCE PER DAY	COINSURANCE PER DAY	COINSURANCE PER DAY	NO DEDUCTIBLE OR COINSURANCE	DEDUCTIBLE FIRST 3 PINTS <i>(or equivalent units of packed red blood cells) in a benefit period</i>
1966	\$ 40	\$10	Not Covered	Not Covered		
1967	40	10	Not Covered	\$ 5.00		
1968	40	10	\$20	5.00		
1969	44	11	22	5.50		
1970	52	13	26	6.50		
1971	60	15	30	7.50		
1972	68	17	34	8.50		
1973	72	18	36	9.00		
1974	84	21	42	10.50		
1975	92	23	46	11.50		
1976	104	26	52	13.00		
1977	124	31	62	15.50		
1978	144	36	72	18.00		
1979	160	40	80	20.00		
1980	180	45	90	22.50		
1981	204	51	102	25.50		
1982	260	65	130	32.50		

HI Premiums

Effective ⁴	7/73	7/74	7/75	7/76	7/77	7/78	7/79	7/80	7/81	7/82
Basic Rate	\$33	\$36	\$40	\$45	\$54	\$63	\$69	\$78	\$89	
Basic Premium Increased by 10% For Each 12 Months of Nonenrollment										

¹ For services furnished on or after January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible for the year in which the services were furnished.

For services furnished prior to January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible applicable for the year in which the individual's benefit period began.

² For care in psychiatric hospital — 190 day lifetime limit.

³ Prior to July 1, 1981, benefits were limited to 100 visits per benefit period under Part A and 100 visits per calendar year under Part B.

⁴ Not applicable prior to 7/73.

Part B — Supplementary Medical Insurance

Deductible, Coinsurance and Payments

General Payment Rule for SMI Benefits:

\$75 annual deductible effective January 1, 1982, (\$60 from 1973 through 1981, \$50 from 1966 through 1972) and 80% of reasonable charges. No payments for first 3 pints of whole blood or units of packed red blood cells in a calendar year (blood deductible). Following are exceptions to this rule:

Inpatient Radiology or Pathology

- Furnished to hospital patients by physicians who agree to accept assignment for all such services
- No deductible
- 100% of reasonable charges

Home Health Services

- From 1/1/73 through 6/30/81: \$60 annual deductible
100% of reasonable costs
- On or after 7/1/81: No deductible
100% of reasonable costs

Provider Services and Services of Rural Health Clinics

- Annual deductible
- Reasonable costs
- Less the coinsurance amounts charged

Certain Outpatient Surgery

- No deductibles
- 100% of physicians' reasonable charges
- Plus a specified amount for facility services

Certain Preadmission Diagnostic Services

- Furnished by hospitals or physicians to outpatients
- \$75 deductible applies
- 100% of hospital reasonable costs
- 100% of physician reasonable charges

NOTE: Annual Payment Limits

1. Outpatient Physician Services for Mental Illness —
50% of reasonable charges
Up to a maximum of \$250 in benefits per year
2. Licensed Physical Therapists' Services in Home or Office —
Maximum annual reasonable charges —
7/1/73 through 12/31/81: \$100 per year
1/1/82 and thereafter: \$500 per year

Initial Enrollment Period

(7 months)

E-3	E-2	E-1	E	E+1	E+2	E+3	E+4	E+5	E+6
X	X	X	C						
			X	C					
				X		C			
					X			C	
						X			C

X — Month of Enrollment

C — First Month of Coverage

E — First Month of Eligibility (ordinarily month individual attains age 65 or 25th month an individual is entitled to disability benefits)

NOTE: Eligible persons will be automatically enrolled for SMI when they first become entitled to HI

General Enrollment Period — Opportunities for enrollment or reenrollment in SMI, unlimited in number, are available from January 1 to March 31 each year, with coverage effective the following July 1. Exception: For the period 4/1/81—9/30/81 only, individuals could enroll in SMI with coverage effective 3 months later.

SMI Premiums

Effective	7/66	4/68	7/70	7/71	7/72	8/73	9/73	7/74	7/76	7/77	7/78	7/79	7/80	7/81	7/82
Basic Rate	\$3.00	\$4.00	\$5.30	\$5.60	\$5.80	\$6.10	\$6.30	\$6.70	\$7.20	\$7.70	\$8.20	\$8.70	\$9.60	\$11.00	

Basic Premiums Increased By 10% For Each 12 Months of Nonenrollment

Time Limit For Filing Part B Claims

Services Received	Claims Must Be Filed By
07/1/66-09/30/66	1968 (April 1)
10/1/66-09/30/67	12/31/68
10/1/67-09/30/68	12/31/69
10/1/68-09/30/69	12/31/70
10/1/69-09/30/70	12/31/71
10/1/70-09/30/71	12/31/72
10/1/71-09/30/72	12/31/73
10/1/72-09/30/73	12/31/74
10/1/73-09/30/74	12/31/75
10/1/74-09/30/75	12/31/76
10/1/75-09/30/76	12/31/77
10/1/76-09/30/77	12/31/78
10/1/77-09/30/78	12/31/79
10/1/78-09/30/79	12/31/80
10/1/79-09/30/80	12/31/81
10/1/80-09/30/81	12/31/82
10/1/81-09/30/82	12/31/83

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7500 Security Blvd.
Baltimore, Maryland 21244



Health Care Financing Administration

